Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

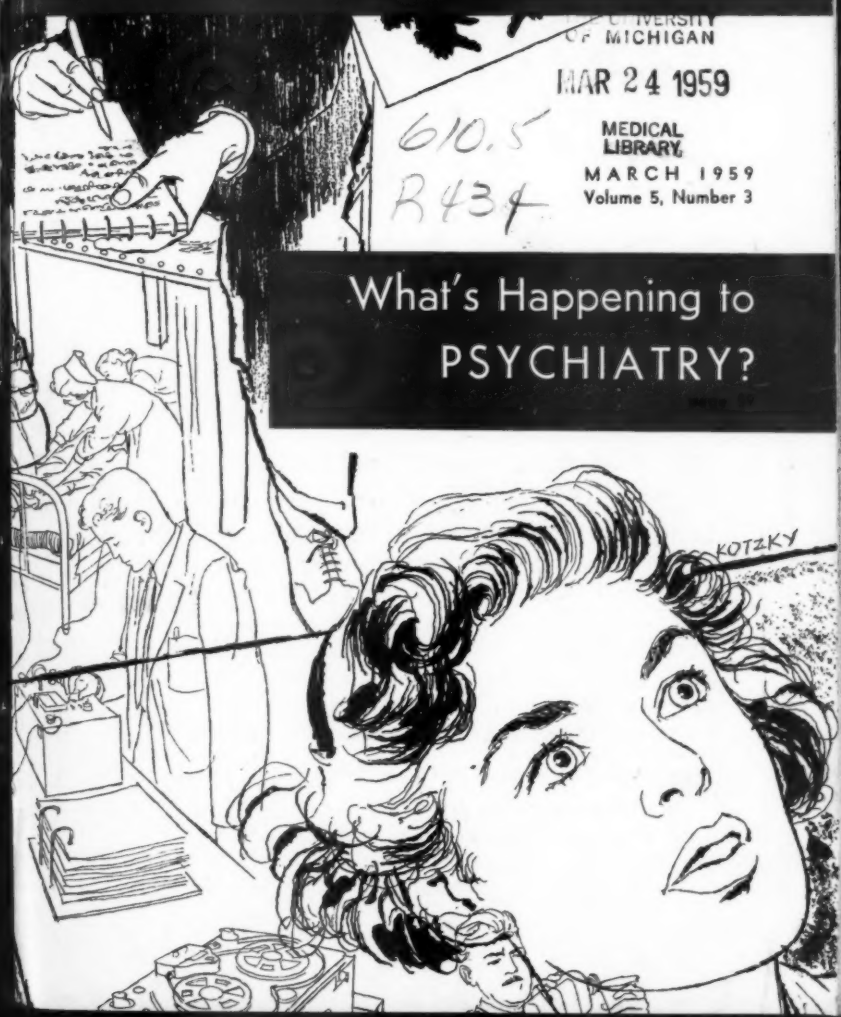
Physician Who Talked Himself Into Trouble

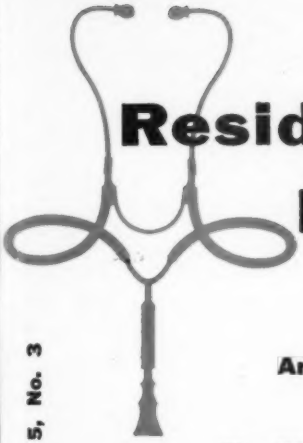
Want a Summer Camp Job?

Questions You Should Ask About Group Practice

MARCH 1959
Volume 5, Number 3

What's Happening to PSYCHIATRY?





Resident Physician

March 1959, Vol. 5, No. 3

Articles

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Resident Physician

Departments

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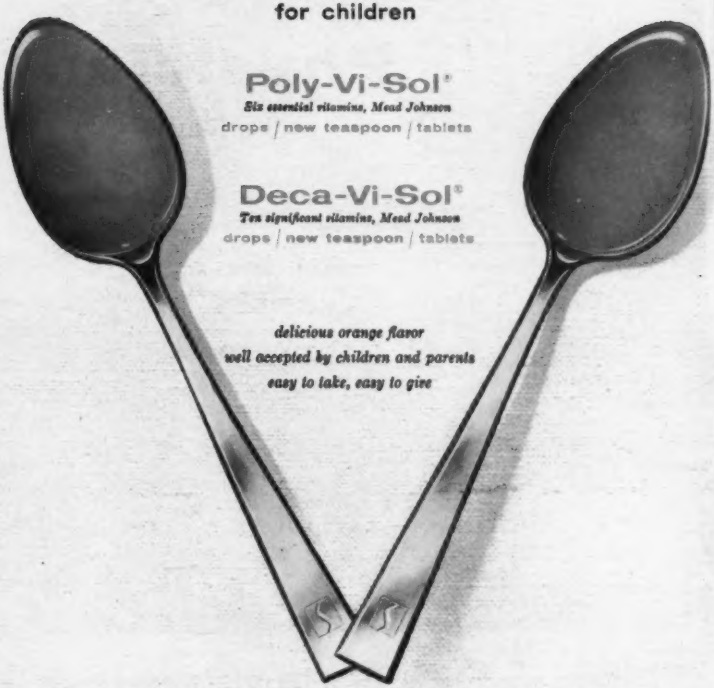

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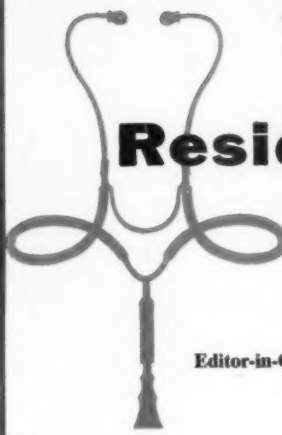
March 1959, Vol. 5, No. 3

Journal for the Hospital Staff Officer



Resident Physician

March 1959, Vol. 5, No. 3

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians. When possible, two copies of the manuscript should be submitted.

Resident Physician

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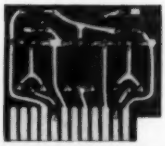
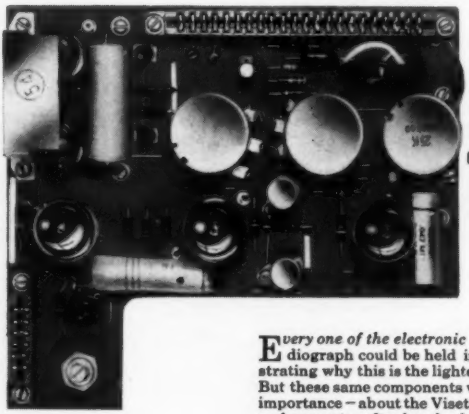
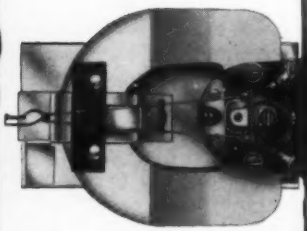
They've put cardiography on the road . . . *with accuracy*







Every one of the electronic components used in a Visette electrocardiograph could be held in your two hands—dramatically demonstrating why this is the lightest, most compact ECG in existence today. But these same components would also prove something else—of *equal* importance—about the Visette: why it can *"take it"*, and *remain* stable and accurate, after hundreds of trips to and from your office.

As you looked at these examples of completely modern electronics used in the Visette, you would see numerous *transistors*—rugged, miniature, solid devices which do many of the jobs vacuum tubes do, but with the advantages of much greater durability, preferable electrical characteristics in certain applications, and an extremely long operating life. You'd also see wiring which was *printed* on thin, tough phenolic panels—in place of hundreds of separate pieces of wire; such connections, of course, can't shake loose under constant jarring—and they also make possible "building block" circuitry in the Visette with separate, easily accessible plug-in panels.

And similar advantages in greater ruggedness, longer life, better performance or smaller size would be found in other Visette elements. *Each one was chosen for the contribution it could make in achieving a smaller, lighter, more rugged ECG—without sacrificing accuracy.* Together, they become part of an electrocardiograph offering unequalled operating convenience and portability. More than 3000 doctors today know this from their own experience—in using a Visette in their own practices.

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Resident Physician

Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

ACIDTYPES *from the Gelusil Family Album* — **FATHER**

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He and the years have passed but his heirs-in-spirit carry on his hard-driving tradition. Gastric hyperacidity is no stranger to them, either. Today, however, you can provide lastingly effective symptomatic relief with pleasant-tasting Gelusil . . . the antacid adsorbent Father should have had.

Especially important to your hospitalized patients . . . Gelusil is all antacid in action . . . contains no laxative . . . does not constipate. Prescribe Gelusil, the choice of modern physicians for every antacid need.

GELUSIL®
antacid adsorbent

WARNER CHILCOTT

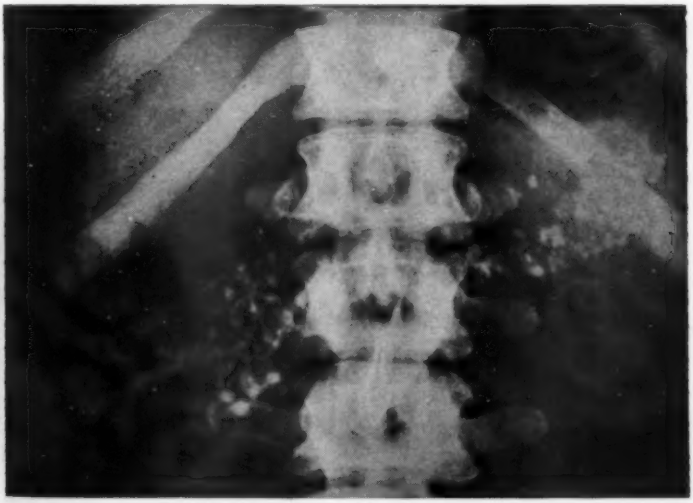
Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

Which Is Your Diagnosis?

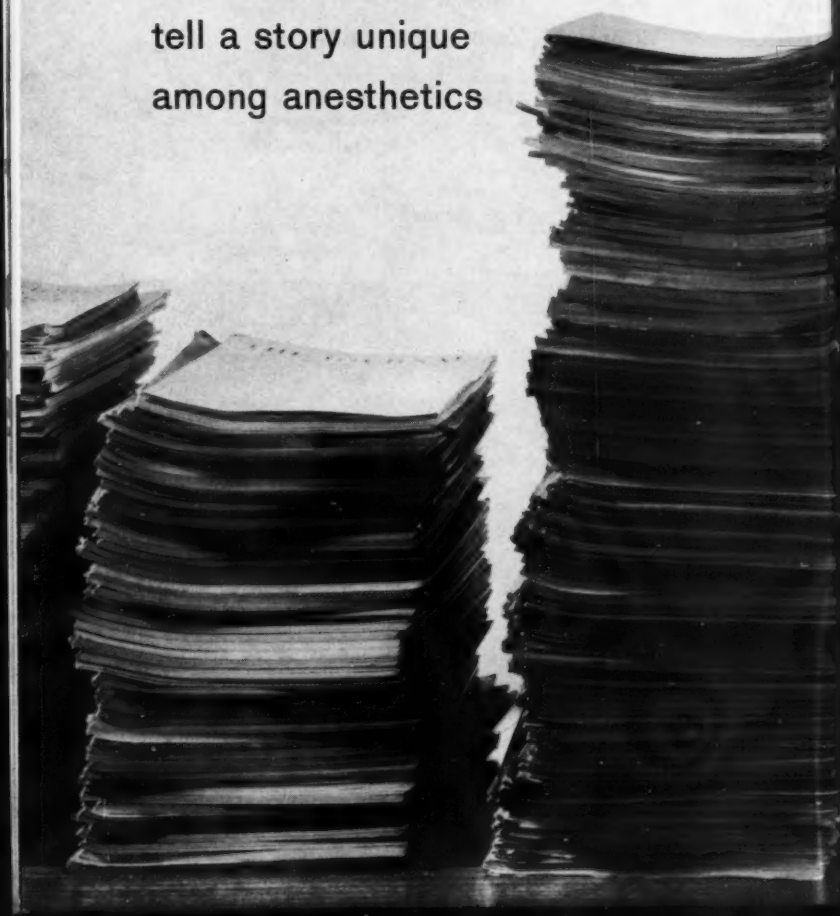
1. Calcified mesenteric nodes
2. Pancreatic calculi
3. Renal calculi
4. Gastric contents

(Answer on page 197)



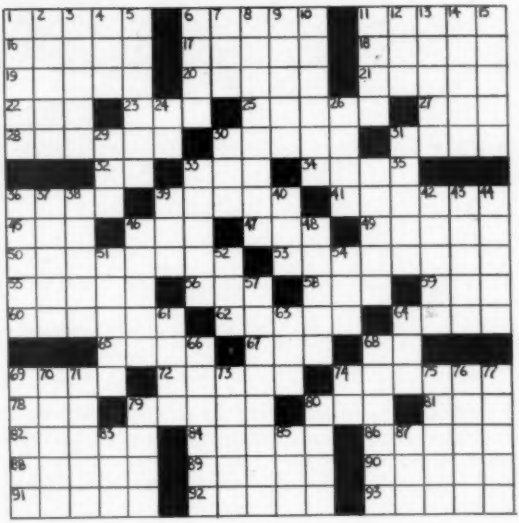
No. 6 in a descriptive series on Abbott specialties

These 3000 reports tell a story unique among anesthetics



Resident Relaxer

(Answer on page 197)



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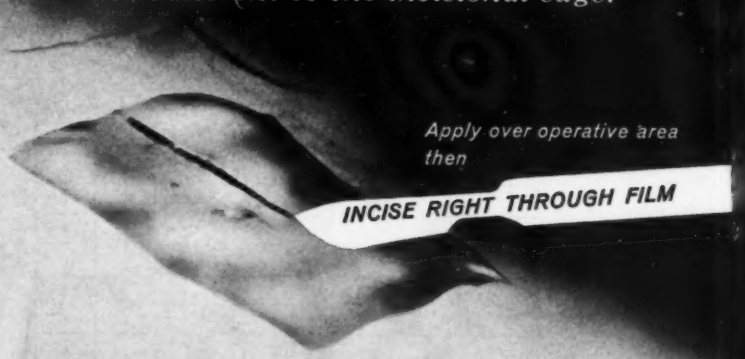
5. Pannier
6. Crust
7. Unit of work
8. Stain for diphtheria
9. Nose of a beast
10. In an easy manner
11. Throw off
12. An affected manner
13. Small insects
14. Lotion (Latin)
15. Upright
24. Preposition
26. Tidy
29. City in Peru
30. Mrs. Eddie Cantor
31. .... Eolie; small islands off coast of Sicily
33. Shaped like an egg
36. Morphea
37. Solitary
38. Radar beacon
39. Plural of egg (Latin)
40. Affirmative
42. Religious ceremonies
43. Dispatch boat (Spanish)
44. Proprietary name for sodio-caffeine salicylate
46. Watchful
48. An inert gaseous element
51. Calcined (Latin)
52. Contemporary physician in Hull, England
54. Citizen (abbr.)
57. Colombian tree
61. Bubonic plague (Japanese name)
63. Gallon (abbr.)
64. The ear (comb. term)
66. A white crystalline amino acid
68. Embryonic area
69. Quality of a sensation
70. Express
71. Physician (prefix)
73. Swelling
74. An abbreviation used in prescriptions
75. Any subjective sensation
76. Pertaining to an atom
77. ——osporidia
79. Continuous pain
80. Network
83. Suffix used in many sciences
85. Pinch
87. Such a one (Latin abbr.)

"a new and nearly ideal skin drape... skin adherent to the incisional edge."[1]



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Patents Pending

1. Adams, Ralph, M. D. : Med. Times, 86:1119-1127 (Sept.) 1958.

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AEROPLAST®
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prompt, high blood levels

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minimal adverse reactions

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Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Berry Plan Vacancies

The editor's page in the November issue of RESIDENT PHYSICIAN stated there were vacancies in the Berry Plan. At present I have completed 17 months of a 3-year residency at the University of Minnesota. About two months ago I inquired about openings in the Berry Plan but was told there were none and was encouraged to enlist immediately. If there are any vacancies, could you tell me where to apply? I enjoy your publication immensely. Keep up the good work.

Name withheld at writer's request

• *It is impossible for us to know when there are vacancies in the Berry Plan since they vary by the month. However, a letter to Frank B. Berry, M.D., Assistant Secretary of Defense, Washington 25, D.C. will bring you the information requested.*

Draft Chances

The Editor's Page in RESIDENT PHYSICIAN of November 1958 in regard to military service had my special interest. However from the information given there it was not quite clear to me whether I could expect to be called for the service in the coming year. I am 32 years of age, married and I have one child. Physically I was classified 1A. However my final classification was IV-F, after I was professionally disqualified in view of the fact that I did not have a medical license in one of the states of the

—Continued on page 38

no asthma symptoms—In asthma, Tedral prevents bronchial constriction and mucous congestion . . . promotes normal breathing . . . permits greater activity. Rely on Tedral to keep your asthma patients symptom-free 'round-the-clock . . . effectively, safely *and* at moderate cost.

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TEDRAL®

the dependable antiasthmatic

WARNER CHILCOTT

—Continued from page 32

union as yet. I will not be able to obtain such a license until some time in 1959.

I would appreciate it very much if you could inform me about my chances of being drafted in the coming year and if so, whether under the present regulations this would be under the doctor's draft or under the regular draft and in the latter case what would be the consequences of this? (In particular: rank, position—and would one be working as a doctor under the regular draft?).

Name withheld at writer's request

• *Here, we believe, are the answers to the questions raised in your letter:*

1. All aliens are eligible for military service under the Draft Act and the Special Registrants Act unless they have had comparable military service in the army of an ally.

2. Whether you are licensed or not has nothing to do with your service as a doctor in the military. Under certain circumstances your medical background may have a bearing.

3. As far as your chances of being drafted are concerned, would not try to answer the question any more than I would try to guess what single number would come up next on a roulette wheel.

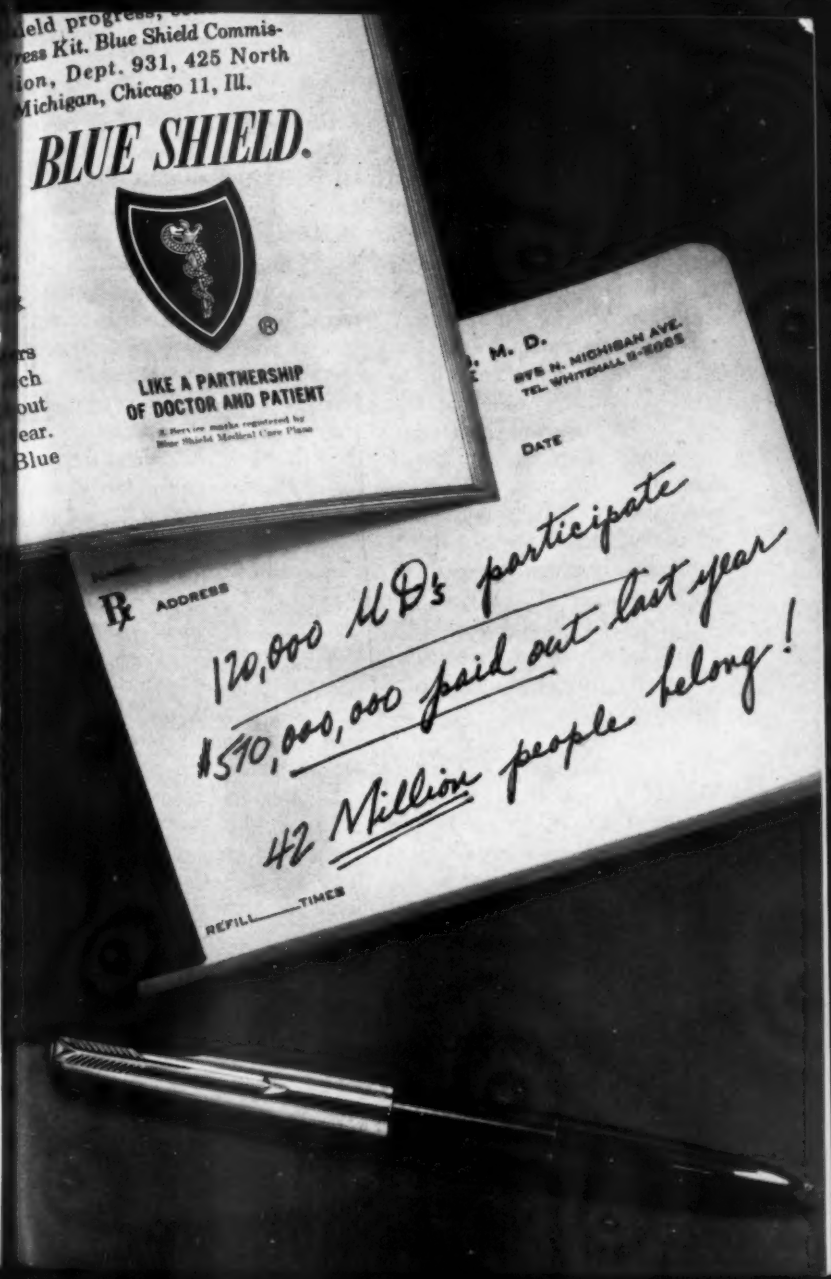
4. Interestingly enough, you can be drafted currently only under the Special Registrants (Doctors Draft), amendment to the regular Draft Act.

5. If drafted, your rank will be that of captain.

Auf Deutsch

As an exchange visitor from Germany I should like to thank you for sending the RESIDENT PHYSICIAN to me which I think is a good and interesting journal. In particular, I agree with Dr. Laxdal (page 38, November issue) in that your publication "The Doctor Speaks" is a helpful series. But I wonder why you have to put so many mistakes in the few pages on "The Doctor Speaks German." I realize, of course, that this country is by and large a monolinguistic country which is not the mistake of her individuals (who are all nice people) but that of an inefficient educational system. And I am satisfied by now to see my own name Americanized almost without exception (Wellman instead of Wellmann).

—Concluded on page 44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OF DOCTOR AND PATIENT
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120,000 MD's participate
$510,000,000 paid out last year
42 Million people belong!
REFILL TIMES

—Concluded from page 38

I am more puzzled to notice that in more than 50 percent of all publications in top medical journals, foreign language quotations (if they are present at all) are spelled incorrectly. Now, when I saw "The Doctor Speaks German," I felt tempted to write to you . . .

. . . I am sure you don't mind my super-critical words, but I think you would not like to see your own language constantly misspelled either, particularly in publications which pretend to teach a little bit of it. Right?

Klaus F. Wellmann, M.D.
Department of Pathology
Milwaukee County Hospital
Milwaukee, Wisconsin

In the November 1958 issue, Volume 4, Number 11, Page 84, RESIDENT PHYSICIAN — in the article "The Doctor Speaks German," I found 157 errors in the spelling of German words.

G. I. Paprikoff, M.D.
Edgewater Hospital
Chicago, Illinois

• *Doctors familiar with the German language are aware that all nouns and certain verb forms are written with the first letter capitalized. Yet, these capitals do not alter the* PRONUNCIATION. *To most of our readers, whose knowledge of language is limited to English, this prolific use of capitals would seem strange and confusing. And since our object was to present to the American reader an easy, quick guide to* SPOKEN *German, we purposely eliminated all capitalization, at the expense of the correct written form. This accounted for all but two of the "errors" referred to. We are sorry for the two unintentional mistakes that somehow got by us.*

Ship's Doctor

I enjoy the RESIDENT PHYSICIAN every month. About one year ago, you published an article concerning positions for ships' doctors. I have misplaced my issue with this article. Would you please send me a reprint of it or the address to which I can write for further information.

H. M. Caffey, M.D.
Georgia Baptist Hospital
Atlanta, Georgia

• *A copy of the article "A Year At Sea . . . as ship's surgeon" is on the way to you.*

Perrin H. Long, M.D.

Editor's Page

THE NATIONAL HEALTH SERVICE OF GREAT BRITAIN: III. Background and Consumer Reactions

It is important that physicians in this country be made aware of what is going on within the British National Health Service, because, with the Veterans Administration, Children's Bureau, the Public Health Service and Medicare providing health and medical care for millions of "consumers" at a cost to the taxpayer, and with the proposed National Health Insurance bill probably coming to a vote in the current session of Congress, and the better than even chance that the Fogarty bill will be passed, all of us can get valuable guidance from the experience of our British colleagues in dealing with governmental control of medical care.

It is important for us to realize that the National Health Service was not the result of a sudden political decision on the part of Labor when it assumed power in 1945. It is fair to say that the roots of the Service go back to the Friendly and Mutual Societies which sprang up over Britain shortly after the dawn of the Industrial Revolution. Certainly, major features of the Service go back to Lloyd George's National Health Insurance Act of 1911.

In the twenties the British Medical Association developed proposals for "a general medical service for the nation."[1] These proposals, revised in 1938 and again in 1942, undoubtedly influenced the Beveridge Report ("cradle to grave" or "womb to tomb"), made public in 1943, in which the philosophy of "full preventive and curative treatment of every kind for every citizen . . . without an economic barrier at any point to delay recourse to it" was a major premise.

We in this country must realize that the National Health Service "conceived by a Liberal, nurtured by a Coalition Government under a Conservative Prime Minister and brought to life by a Labour Government . . . can justly claim to be a national institution."[2] At its inception in July 1948, it represented to the best of their various abilities the *consensus* of the British medical profession, public, and politicians relative to the provision of health and medical care for the people of Britain. Nearly eleven years have passed and it seems possible for one to assess seriously the benefits and drawbacks of the National Health Service.

The story is told of a well known American physician who, after being hospitalized while visiting England several years ago, was asked: "How was it?" "Well," he replied, "I paid nothing and got nothing." This attitude, I think, is completely belied by the following quotation from Dr. H. Guy Dain, a former chairman of the Council of the British Medical Association, who writes: "From the point of view of the 'consumer,' that is, every inhabitant of the country, whether Britisher or visitor, it [the Health Service] has been an enormous benefit and success. In no other country, whether welfare state or not, is it possible to have, on requirement, all of the professional services that may be needed for the treatment of all kinds

of illness or accident without fee or charge; consequently without any hesitation to call for help on account of the possible cost . . . for the patients the Service has been a boon, and the knowledge that it is there and available has been a great comfort, even at the time when you have no need for it yourself. The absence of any financial barrier between doctor and patient must make the doctor-patient relationship easier and more satisfactory."[1]

In a recent survey made by Professor Gemmill on patients' dislikes and likes about the National Health Service, it was clearly documented that while the patient *does not like* having to wait too long in doctors' offices, the relatively small amount of time given him by the busy practitioners in their examining rooms, the deductible costs for dentures ($12); for dental service ($2.80); spectacles ($4.20), and prescriptions ($.14), and the provision of free care to foreigners (an xenophobia which is interesting), he greatly enjoys "the fact that medical provision is now a *right* and not of *charity*," that excellent medical care is now available to everyone, that the cost of "catastrophic illness" now carries no threat of wrecking one's finances, and finally he greatly appreciates "the comprehensiveness of the Service and its nation-wide coverage."[2]

Last July I found no dissenters from the point of view expressed both by physicians and patients with whom I talked, that the National Health Service had been responsible for bringing about marked improvements in the health and medical care of the people of Great Britain, and there was no question but that the National Health Service was there to stay.

I think all of us in this country should consider this "consumer" reaction in Great Britain, because I am absolutely certain, after observing what has happened since 1945 as the result of the vast expansion of the Veterans

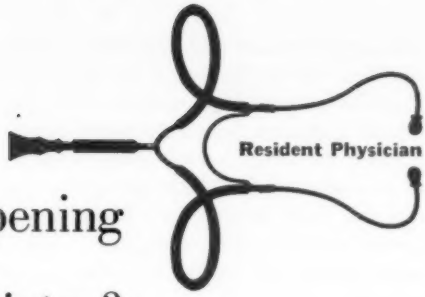
Administration's Medical Service, the increase in the activities of the Children's Bureau, the phenomenal growth of the Public Health Service, the reception of the relatively recent Medicare program, the growth of the Health Insurance Plan, and of the United Mine Workers' and other governmental and union organizations for health and medical care, that none of these schemes will ever be relinquished by their clients.

The medical profession must face the fact that if they can get it "cheaper," or "free," the chances are overwhelming that the majority of the American people will support health and medical plans which purport to provide them with services under such terms.

---

1. Dain, H. Guy. Brit. Med. J., 2, Suppl. 1, July 5, 1958. 2. Editorial Supplement. The Times (London), July 7, 1958. 3. Gemmill, Paul F. Brit. Med. J., 2, Suppl. 17, July 5, 1958.

Perrin H. Long.



What's Happening to Psychiatry?

Is it the psychiatrist's purpose to assist everybody to adjust into a painless conformity, or should he concentrate on persons suffering a serious disturbance of mental health? In the near future, states the author, we may find ourselves faced with a critical re-examination of psychiatry's role in society.

George A. Reynolds, M.D.

We are, all of us—like children of immigrants—first generation Americans, living in a new and different land; suspended between the "old world" of our parents and the "new world" that is the America of today and tomorrow.

Consider the changes taking place all about us. We see change in the size, composition and geographical distribution of our population. We see the explosive growth of suburban areas with all the problems such growth entails. We see technological advances altering the pattern and substance of our way of life. Ever-broadening media of mass communication make sure that mass production results in mass consumption.

Medical practice is not immune to these changes. Medicine can be studied in the relatively isolated world of the laboratory

and lecture room. But medicine must be practiced in the world as it exists. As resident physicians we are concerned primarily with learning the subject matter of one of the specialties of medicine. I think we must at the same time give some thought to the problems which will confront us in practice.

Psychiatry

How will changes in the field of psychiatry affect the future practice of the residents of today?

It is paradoxical that while the problem of mental illness is age-old, modern psychiatric knowledge is relatively new. When we read the names of the great pioneers in our field, I think we sometimes forget how close we are to them in point of time. Freud, for instance, died as recently as 1939. Dr. Adolph Meyer died in 1950.

Our specialty, still in its childhood, so to speak, is facing the tasks of manhood. In 1936, it was estimated that 1 out of every 20 Americans would spend some portion of his life in a mental institution. In 1957, the estimate was 1 of every 12 Americans. We not only have a rapidly increasing population but also an increasing demand by that population for psychiatric care.

Whole new subspecialties of psychiatry are developing. The field of child psychiatry comes to mind first. Not so well known,

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Following Army service, Dr. Reynolds was staff physician at San Antonio State Hospital and since 1957 has been a career resident in psychiatry at Fort Roots Veterans Administration Hospital, North Little Rock, Arkansas.

perhaps, is a field such as industrial psychiatry. Dr. Ralph T. Collins states that "Each year brings more interest in the emotional problems of employees by industrial medical departments. The impact of such problems, on-the-job and off-the-job, is slowly being recognized."

Several large corporations now have full-time psychiatrists as members of their medical departments.

Specialized fields

There are other specialized fields: Forensic, administrative, and military, to name a few. Psychiatrists have been asked to serve as consultants not only by their colleagues in other branches of medicine but also by a variety of public and private agencies, boards of education, and military, religious and industrial organizations.

For example, psychiatrists have aided in the screening and training of government personnel going on foreign missions. And they have served as participant-observers in groups, responsible not only for their contributions to the particular problem at hand but also for attention to the interpersonal relationships involved in the actual functioning of the group.

We do not have adequate numbers of trained personnel to meet the needs. In May of last year, Dr. Harry C. Solomon, delivering his presidential address in San Francisco before the annual meeting of the American Psychiatric Association, said: "After 114 years of effort, in this year of 1958, no state hospital has an adequate staff." Chronic patients are "accumulating in an atmosphere of gloom, despair and deterioration."

Dr. Daniel Blain, former medical director of the American Psychiatric Association, has estimated that it would take 20 years to double the present number of psychiatrists," but we need twice our present number right now."

We are not training psychiatrists at the maximum possible rate. Statistics indicate that as of September 1, 1956, only 73 percent of psychiatric residency appointments were filled, a total of 2166. A year later the number of residents had increased to 2511 but this was only 76 percent of available openings.

Contact

What changes must come if we are to meet the demand? For one thing, we will have to continue intensive efforts to attract new men to the field. What can the resi-

dent group do to increase recruiting? They can fraternize. They can get to know their interns and any medical students working on their wards. They can show by their physical presence that psychiatrists do not all live somewhere in outer space. This may sound silly but I am convinced that incipient interest in specializing in psychiatry often dies for lack of encouragement and lack of contact with men in the field.

For chiefs of service I can offer one suggestion. Make every effort to publicize training opportunities in those journals aimed directly at the man in general practice. Make sure that general practitioners find out all the details about the "career programs" which make it possible for a family man to take residency training without either starving his children or going prohibitively into debt.

Proposals have been advanced to change the medical curriculum in order to produce more psychiatrists at an earlier age. One suggested plan would reduce the present courses by 25 to 40 percent of their present hours and utilize the time thus released for concurrent study in psychiatry as a specialty, leading to a degree of Doctor of Psychiatry or Doctor of Medicine in Psychiatry. I believe that proposals of this type fail to take several things into consideration.

First, it is a rare student who enters medical school aiming at a given specialty who eventually ends up practicing in that specialty. This is fortunate; otherwise, we would all be surgeons.

Effects of disease

Particularly in psychiatry, the field seems to be full of "Johnny-come-latelys." While this is not necessarily good in itself, Dr. Jurgen Ruesch has pointed out that many major contributions in psychiatric thought have been made by men in their mature years and particularly by men who have had a broad experience in terms of cultural changes, personal experience with disease, or changes in occupation or specialty.

Second, psychiatry is a branch of medicine, not an ancillary profession like dentistry or psychology. Members of such ancillary professions must be grounded in the basic medical sciences and acquainted with medicine, but a psychiatrist must be a physician. He must be familiar with the effects of disease on a patient and must know disease processes so that he can better understand how these processes can break down

a patient's psychological defenses and expose his underlying personality. He must understand how certain toxins and diseases can cause psychiatric symptoms. For instance, many neurological conditions are mistakenly treated as psychiatric disorders in the early course of the disease.

Total health

Third, a neurosis or psychosis does not confer an immunity to other disease. In the world as we find it, a phychiatrist must frequently be responsible for the total health of the patient, at least to the extent of recognizing that a medical or surgical problem exists and referring the patient for appropriate care. This is particularly true of institutional practice. As head of the psychiatric team, the psychiatrist is responsible for the medical complications that arise in the course of psychotherapy. Neither the psychologist nor the psychiatric social worker should be expected to make a differential diagnosis of polydipsia and polyuria caused by anxiety versus diabetes mellitus versus diabetes insipidus versus genitourinary pathology.

Fourth, such an approach to the training of psychiatrists is essentially vocational, not professional. It would result in the training of psychotherapeutic technicians. Such technicians might be very proficient in the application of methods of treatment but how much could we expect from them in the vital areas of interpretation and judgment? How far could we expect mere technicians to advance the frontiers of psychiatric knowledge? More importantly, has the body of psychiatric knowledge really reached such size and certitude that we can train technicians?

Influence

In the actual practice of psychiatry, we will, deliberately and consciously, have to seek every possible way to extend the influence of each individual psychiatrist to enable him to reach more people. We are going to have to use the "team approach" as much as possible.

We are going to have to exploit the concept of the therapeutic community and utilize the techniques of group therapy to the greatest degree possible. We must combine techniques, for example, televised psychodrama.

We must divest ourselves of whatever tasks can be delegated. Is it really necessary, for example, for a trained psychiatrist to write every order for every enema given to every senile patient on

the old folks ward? Can't we let the nurses do the nursing?

We must learn to work through people with less training. The American Academy of General Practice and the American Psychiatric Association in 1957 initiated a joint project aimed at developing practical methods by which the general practitioner can be shown how to handle a greater share of the nation's psychiatric problems.

When the Republic of Mexico attacked the problem of illiteracy in her people, the slogan "Each one teach one" was used. I think we are going to have to adopt that philosophy. I am not advocating a wide open program of "do-it-yourself" psychiatry. I am advocating that we try to teach our colleagues in other branches of medicine what they can handle and how they can handle it so that we can be free to handle those cases requiring special skills. And please, when we talk to our fellow physicians, let's spare them the psychiatric jargon. They do not understand it and it often serves only to irritate and frustrate them. On the practical level, if we cannot be understood, our services will not be sought.

In addition to trying to attract more people into our specialty and in addition to more efficient use of both professional and lay personnel, Blain and Robinson suggest that we try to cope with personnel shortages by attempting to reduce the demand for clinical psychiatric services. Does every man who hates his job or every child who wets the bed need psychotherapy? Or can many of the less severe maladjustments be adequately dealt with by the general practitioners and an expanded network of the community agencies which are presently in existence?

Is it our purpose to assist everybody to adjust into a painless conformity or is it our purpose to treat persons suffering a serious disturbance of mental health? In the future we may find ourselves faced with a critical re-examination of the role we psychiatrists have to play in society.

Speaking before the Tenth Annual Institute in Psychiatry and Neurology at the Veterans Administration Hospital in North Little Rock, Arkansas, Dr. Solomon stated that of the approximately 10,000 members of the American Psychiatric Association, about 2100 or 2200 are located in New York and about 1100 in California.

In other words, nearly one-

third of our psychiatrists are located in two states.

There are other concentrations of APA membership in Massachusetts, New Jersey, Maryland, and Washington, D. C. We can assume that there are other concentrations of psychiatrists in any city having a psychoanalytic training institute. The immediate conclusion is that there must be all kinds of opportunities, both private practice and salaried positions, in the rest of the country.

One observation of my own I would like to mention here is that a psychiatrist who opens up a practice in some community which is not a medical or psychiatric center may find that he is expected to do a fair amount of neurology. In many places there are few others with much training or experience in neurology.

One idea we might try in private practice would be an adaptation of the "circuit rider" technique. In undermanned areas, a psychiatrist might be able to work out an arrangement whereby he would be available at regular intervals for consultation-clinics in other communities or in family doctors' offices. This idea has been used in psychiatric consultation work and it should prove adaptable to a variety of circumstances.

Smaller centers

What changes will we see in the large public mental hospitals? In his San Francisco speech mentioned above, Dr. Solomon recommended the establishment of small clinics and hospitals located near the patients' homes and jobs. Instead of having large, isolated mental hospitals acting as catch-alls, the trend will be to have more, smaller treatment centers, probably set up in conjunction with existing clinics and community hospitals. These small treatment centers could take various forms: outpatient clinics, psychiatric wards in existing hospitals, or day hospitals. They will take the treatment to the patient and keep the patient in the community. They will at the same time act as filters for the large, custodial type of hospital which will be reserved for chronic patients.

The longitudinal pattern in psychiatric therapy means relating the referring physician to the therapy of the patient both during and after psychiatric treatment. In the past, patients were dumped into the mental hospital. If they happened to recover, they were dumped back out. There was little communication or follow-up between physicians on either side of the iron bars. This

condition is passing and we are now seeing a closer integration of psychiatry with other branches of medicine. One sign of this is the establishment of psychiatric wards in general hospitals. Another sign is the positive efforts being made to interest local general practitioners in serving as part-time staff members of mental hospitals in their communities, to care for the general medical aspects of treatment. This also permits the psychiatrists to concentrate on specialized therapy.

Elder citizens

We are going to have to find some way to separate geriatric care from psychiatric care in the state hospital systems. There is an increase in the number of elderly people who cannot be cared for at home, but shifting them into the mental hospitals overloads these institutions far past their effective capacity as treatment centers.

Geriatric domiciliary centers could be set up and run at a considerably lower cost both in terms of money and scarce skilled personnel. The state hospitals, thus freed of the load imposed by giving custodial care to the geriatric patients, would be able to function more effectively as treatment centers.

Research is really our great hope in coping with the increased demands. The need for research in psychiatry is desperate but the shortage of research workers is even worse than the shortage of psychotherapists. Drs. Alexander and Moore in a recently published paper advance the thesis that schizophrenia is not a disease entity but may actually be a group of diseases. If we can refine our diagnostic techniques, then we may be able to devise treatments which are more specific, more effective, and less time consuming. Any attempts to accomplish this will have as a first and essential requirement a broad program of research.

There is a great deal of interest in psychoanalysis on the part of today's residents and there appears to be the beginnings of a rapprochement between psychoanalysis and other branches of psychiatry. I believe that analysis and other time-consuming techniques will continue to make their contributions, but their value may lie more in the area of research than in the area of therapy. I am not questioning the validity of psychoanalysis as such, but I am suggesting that it might not be very realistic to expect the method of extended individual analysis to meet the

overwhelming demand for treatment.

We psychiatrists appear to be facing a dilemma. We are committed, by implication if nothing else, to treatment of the individual patient. More than any other branch of medicine, more than any other field, including the ministry, we probe into the depths of the individual personality. Yet with tremendous volume of work to be done, group therapy and other techniques designed to reach large groups must be widely used. Perhaps this may not be as paradoxical as it seems. Such techniques, although using the group approach, help the individual patient probe into his own depths and thus achieve insight.

It hardly seems necessary to mention the advances that are taking place in drug therapy. The tranquilizers have enabled many formerly hopeless patients to leave the hospital. There is no reason to believe that chemotherapy has been exploited to the fullest. However, I do not expect pills and elixirs to replace the psychiatrist. They will enable him to work more effectively.

Psychiatry is not the long-sought panacea that will solve all the ills of mankind and so bring about Utopia. It is but one of the branches of medicine. And by any measure, psychiatry's contribution to the sum total of human welfare and happiness will be determined solely by its care of the mentally ill. Thus, we must face today's challenge realistically and of necessity seek the help of other physicians, educating them to treat those mental conditions well within their ability to treat; we must encourage younger physicians to enter psychiatric training. And alert to the overwhelming need for psychiatric care, we must re-design facilities, initiate an aggressive research program, and adopt those techniques which will permit psychiatry to accomplish the greatest good for the greatest number of mentally ill persons.

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If you want an outdoor vacation for you and your wife— and get paid for it, too . . .

How About a Summer Camp Job?

From Maine to California, Minnesota to Florida —and most places in between, directors of summer camps for kids are looking for doctors. And they're looking right now, this month.

You can get sun, fun and good food—plus a salary—for watching over the infrequent hurts and occasional fevers of a group of these vacationing youngsters.

Can you handle the assignment? Keep this in mind: most kids who have summer health problems are involved with such things as U.R.I., poison oak or ivy, superficial lacerations, bruises, abrasions—with an occasional behavior problem thrown in. And for the rare child who develops something

What do summer camp directors expect of a physician? One expressed it this way: "First, I want a man who is professionally qualified. Training references help us determine this. Second, personality really counts. Most people think of summer camps as vacation playgrounds, baby sitters away from home. In part this is true. But more important, we think, is our educational responsibility, helping the child toward emotional maturity—teaching him to accept responsibility for himself and others. This is where the physician's personality comes in. If he is really interested in the children, he gives them con-

indicating a need for hospitalization, you should be able to recognize that fact.

Remember, camp authorities will ask you to supervise an outpatient clinic, not a children's hospital for acute diseases.

If, by chance, you are asked to do more than that, you'll know what to tell them without our prompting.

Better start

If you're not locating this year —and if you happen not to be rich enough to afford a luxury cruise, you might just be thinking of earning a little something to help you get off to a better start in your practice come November.

And if that's your case, look into summer camp openings. Here's a golden opportunity to get paid a salary where there's little opportunity to spend it.

At the same time you'll be able to run your own little private practice. You'd be surprised at the practical information you'll pick up applicable to your own practice later on.

Perhaps you're right in the middle of your residency, have only a few weeks vacation coming. It'll still work out. Many camps allow what they call a "split season," take on one resident who guarantees them a replacement from among his col-

SALARY—What is the exact salary? (Is there a contract?) Most camps figure your pay by the season, vary from $500 to $900 for a 7- to 10-week season. How is the salary paid? At the end of the summer period, weekly, or monthly?

fidence, guides them away from an overconcern about minor cuts or temporary malaise. In short, he helps them grow up. This doesn't require a grim scientist—simply an affable, outgoing human being who is competent — and interested in the children under his care. We ask the same of our counselors: Competence, common sense, and interest in the children."

leagues to finish out the season.

You can team up with another resident and stagger your vacation times to give full season coverage to one camp.

Early application

After all, most educators heartily endorse the idea of your taking a real break from the hospital routine—out in the wide open spaces where you can get a little tone and color into your body. (Man, have you looked in the mirror lately?!)

In any event, if you think this is a good plan for you, get started now. Camps hire ahead of time; they're now filling July through August positions. Your application may be a week early. That won't hurt. But if it's a week late, you're out of luck.

The growth of summer camps during the past ten years has been just short of phenomenal. Bigger families, a rise in the general economic level are two reasons. Along with the growth and development of summer camps, there has been a tremendous increase in the demand for camp physicians. *Jobs are plentiful enough so that the resident who starts looking early* usually will get one that fits his specifications.

Hospital bulletin

One of the quickest and perhaps easiest ways to find out about openings is to keep an eye on your hospital's bulletin board. Most camps start sending out notices to hospitals in their areas about February. If you haven't seen any posted in your hospital, stop in and see the administrator's secretary. She may know of some that have come in but, for some reason, haven't been put on the bulletin board.

Your local medical society frequently will get a request for camp physicians. A telephone

WIFE—Are there facilities for your wife and family? Some camps will give your wife a job as your aide or a group leader or camp supervisor; some may accept your children at a reduced fee. Ask about this.

✔ **LICENSE**—Is a state license needed in the state where the camp is located? The camp will probably have this information from past experience. For example, in some areas this is a must, in others a temporary license will serve the purpose, and in some it is required of a physician to be eligible for a state license and have a licensed M.D. in town as supervisor.

✔ **ASSISTANT** — Will you have an assistant? Many camps will have a nurse on the payroll. Most won't. Some may have a medical student as a counselor. Needless to say, a junior or senior medical student will be invaluable.

✔ **CONSULTATION**—Are there hospital facilities in town? What arrangements has the camp made with the hospital? Is there a local physician available to help you when needed for consultation? Have arrangements been made for you to hospitalize a seriously ill child?

✔ **DISPENSARY**—What are the facilities of the dispensary? How well is it equipped? Be specific. Do they have an inventory of medical supplies on hand? Who is to decide what materials are needed. Will they take your recommendations as to the needs and supplies of the dispensary?

call to the society or a careful look-through of the classified section in the society's journal may turn up something.

Agencies

Established physician placement agencies in your area are excellent sources for part-time and summer camp positions. (You will find their ads in the classified sections of this and other medical journals.) Many camps list with the same agency year after year. The agency can help you evaluate the kind of set-up you will be getting into. Again, if you apply early, you'll get your pick of camps.

In your letter to the agency, be sure to give dates and desired areas. Since a personal interview with camp authorities is usually necessary, you'll probably be wiser to limit your preferences to your home or hospital area.

Newspapers

The Sunday supplement and classified sections of metropolitan newspapers may contain a few ads calling for camp physicians. If you are in a small town with a newspaper of very limited circulation, this is less likely to be true.

How about letters? Certainly.

Writing directly to camps you may have attended or to a camp that you've heard about may turn up something.

A few of the national and "family" circulation magazines carry ads of summer camps. While there won't be any ads for camp physicians, you will get a good supply of camp names and addresses; also, camp associations.

Associations

Frequently, camps will be grouped together in an association based on religious, fraternal or regional basis. The YMCA and the YMHA, the Boy Scouts, Girl Scouts, Police Athletic Leagues, certain church and religious organizations often have many camps under a group jurisdiction.

It may prove a good shortcut to write directly to the camp association headquarters requesting information about physician openings in any of their summer camps.

One big national group, the American Camping Association, maintains headquarters in Martinsville, Indiana and has regional or district offices located around the U. S. for placement of camp counselors, nurses, and physicians. Write to Hugh W. Ransom, Executive Director, at the headquarters. Be sure to mention the areas you are most interested in.

Brief

In your first letter to any camp inquiring about an opening, give a brief résumé of your training, licenses if any, and the exact date you will be available.

Also, request some screening information from the camp. For example, find out what period you will be required to serve and the probable salary.

This is one way to eliminate the negative. For instance, it's obvious that if the camp wants you to start before your residency is completed, it would be a waste of your time to continue the correspondence with this particular camp.

✓ **SPECIAL CARE** — Must all children have physical examinations by their private physicians *prior* to their acceptance by the camp? Will the camp knowingly accept diabetics, allergic or cardiac children (requiring constant and specialized care)? If so, will you be responsible for their maintenance therapy and management?) If the camp makes an extra charge for such children, will you receive a fee?

✓ **DUTIES** — Do you have any other duties besides strictly "professional care" of the campers and camp staff? Some camps try to have their physicians double as nature counselors or advisers.

✓ **MALPRACTICE** — Are you covered by a malpractice policy? If not, will the camp pay for such a malpractice policy if you take one out for the duration of your camp job?

✓ **PROBLEM WIFE?** — We mentioned that your wife may be welcomed at camp, all expenses paid. But, in our talks with a number of camp directors, we learned of one problem: *The wife with nothing to do.*

By and large, camp directors consider the camp physician's wife a problem—*unless* she is willing to help out in some small way with the camp's activities. Camp directors will usually offer her some job as assistant to a counselor, arts and crafts supervision, picnic manager, or some such position—and are happy to pay her for her efforts. So if you want your wife to be with you at camp, make sure you let the director know her qualifications for helping out—and the fact that she is willing to accept some responsibility in connection with the camp's operation.

If your letter is satisfactory and the distance is not too great, the camp will probably request a personal interview.

Prepare yourself for this as you would for any interview. Also consider the fact that in this particular position there is just as much you want to know about the camp as the camp must know about you. Be ready to give answers.

Throughout this article are checked (✓) paragraphs that may help you frame some of the important questions.

Past experience has shown that the answers to these questions largely determine what kind of summer camp tour you will have.

Remember, all these items needn't wait for a personal interview for clarification. Many should be handled through your correspondence.

Salary

Since camps are having quite a bit of difficulty in getting doctors, you're in a shopper's market. Don't jump at the first salary offer (unless you are completely satisfied, of course). You will be in a position to negotiate a bit. Perhaps you might suggest a higher figure and then work back to a compromise.

Or, if the camp is particularly

desirable from your point of view, work on a few possible fringe benefits which have not been offered. Such things as your wife's job or maintenance, and that of your own children, your days off, etc. — all are things which can be negotiated.

Value

Don't undervalue your own usefulness to the camp. You *may* have to work your head off throughout the summer — in which case, it would be nice to have something in the bank to show for your efforts.

Incidentally, many private camps will offer you more in salary than will some of the organization camps such as the Scouts, fraternal groups, etc. But there is no "standard" rate. Perhaps it should depend on the number of children involved and how much each child must pay to come to the camp—but it doesn't.

You will have to develop your own evaluation, unless you are working through a medical placement service.

Of course you are expected to work. You are getting paid a salary for that. But at the same time make sure that you will have sufficient time and coverage for a reasonable amount of enjoyment and relaxation. It is too late to discover after you've worked for several weeks that you have tied yourself to a bad deal.

Try to arrange for such things as salary and time off and equipment *before you sign.*

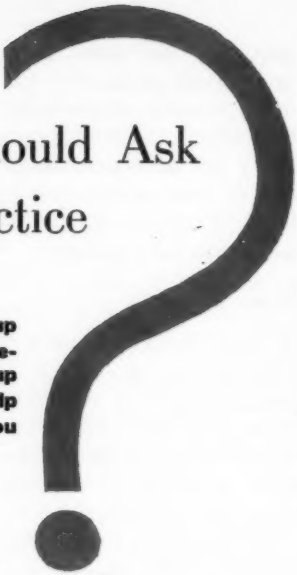
If the job fits, take it. Summer camp can be a refreshing experience after a long year in your hospital.

See classified ads in this issue —Page 194. ED.

COVER — Here are important items which should be settled in advance! What are your days off, if any? Will you have anyone to cover you? In some camps the physician is on duty the day he starts to the day the summer ends. In others, the physician will have one day off, or one week end off periodically; his place will be taken by a local physician from town. This depends on arrangement between you and the camp, but it is always better to settle these points before the contract is signed.

NEXT MONTH: Vacations—Plain and Fancy

Questions You Should Ask About Group Practice



Division of income, personality of group members and many "little things" determine success or failure in group practice. Here are some facts to help you measure any group—before you take the plunge.

Joseph Axelrod, M.P.H.

The fees charged in group practice approximate the prevailing fees charged in the community by non-group physicians. Surgical and delivery fees tend to average higher, probably because group physicians are more often board qualified specialists in their fields than are solo practitioners who may be GPs, or GPs who limit their practices to a specialty.

Essentially, the factors of ability to pay, cost of provision of service and sometimes value of benefit to the patient are employed to vary the fixed amount method of fee determination.

The establishment of a particular patient's ability to pay and of the cost of provision of service are functions performed by the business manager of a group practice and his personnel. The

The first of this two-part series on group practice appeared last month.

physician is relieved of fee-setting and fee-collecting.

Group income

Income distribution among the physicians in medical groups is usually done by division of net income, by salary or some combination of the two. Since the majority of groups are partnerships, some drawing account arrangement is made plus periodic sharing of net income after expenses. Non-partners may or may not share in net income depending upon their terms of employment and stage of progression toward partnership. Although no perfect method or formula exists for group income distribution, the following factors are usually considered: competence, experience, training, tenure, administrative responsibility, investment, "book value" of work done, special contribution to the group in ability, scarcity of special skill, ability to attract new patients, and contribution to elevated quality of group care.

Point system

Many groups establish a point system for crediting each doctor's "account" with services rendered to patients and the other variable factors previously agreed upon. The individual physician's share of the net income is calculated from the number of points in his account relative to the total of points earned in the group. The method of straight percentage distribution by prearranged formula among physician partners is also common. Some groups use

About the Author

A graduate in chemistry of the University of North Carolina, Mr. Axelrod worked for a number of years as an industrial chemist prior to entering the Air Force during World War II. In 1949, he assumed his present post as administrator of the Montefiore Hospital (New York City) Medical Group; the first such group in the country to be formally organized as a department of a voluntary hospital. The author took a leave of absence for a year's study at Yale University leading to a Master's degree in Public Health. He majored in medical care administration. Completing his studies at Yale in 1951, Mr. Axelrod resumed his position as administrator of the Montefiore Group composed of 52 physicians and serving 25,000 insured patients.

year to year salary agreements based on experience and depending upon the individual physician's tenure, training, and volume of services. Variations and combinations of the income distribution methods described are often found, particularly in groups having founding, senior, junior and aspiring partners.

Additional benefits

From available data, it is evident that physicians in private group practice earn at least as much as their opposite numbers in individual practice and perhaps more. Annual cash income to physicians in group practice is usually augmented by other benefits which have money value and are so considered.

Most medical groups provide some or all of these additional benefits: paid vacations, paid sick leave, paid professional meeting time, paid auto purchase or rental, malpractice insurance, life insurance, health and accident insurance, and pension and retirement programs.

Wide variations exist in the number of paid leaves and in the amounts of insurance, but even the least of these seem to be considerable and represent equivalent cash income.

Many groups encourage research and publication by providing to some degree laboratory space, technician time, special equipment, clerical and secretarial help, reprint purchase allowance and extra time off with pay to present papers at professional meetings.

Doctors and patients

Proponents of group practice point to the advantages of the team approach; competent consultant specialists in a common plant, using equipment jointly for efficiency.

This, claim the group adherents, is the best organizational pattern for medical practice. Physicians are stimulated to their best efforts; a high quality of medical care can be expected in a group, where each works with his fellow physician, figuratively, "looking over his shoulder."

Also, ready access to consultation means the patient gets complete care; it also provides an opportunity for a continuing postgraduate training for referring physicians in the group.

No waiting

The physician starting out in a private solo practice spends the major part of his time waiting for patients. Meanwhile, he will usually lose some measure of his

proficiency and realize little income.

Physicians who enter an existing group practice are assured immediately of patients to treat and a sustained income.

The cost of a medical education in a specialty is so high at present that the usual delay in attaining net income in solo private practice is one which few doctors can afford to face. The trained specialist may not only lose proficiency during the early years of his solo practice, but the "waiting period" represents a tragic waste of ability which is in short supply.

Economy of operation and freedom from administrative detail are other advantages of group practice, especially freedom from the fee collection feature of solo practice.

A group of physicians providing general medical and specialist care obviously needs far less space and equipment to practice together than if they maintained separate facilities.

Perhaps one of the most appealing advantages of group practice is the ability to share the emergency work on nights, weekends and holidays without fear of neglecting patients.

Longer vacations and more free time are the rule in group practice.

Opportunity for rest, relaxation, postgraduate training, research and a decent family life are possible and more in evidence in group practice than solo.

The patient usually benefits, too. The caliber of medicine can be better by virtue of better facilities, readily available consultation and easy access to laboratory work. The patient saves time because the complete diagnostic and consultation service is under one roof. This convenience often helps bring him in earlier and more frequently.

The patient benefits by less expensive service, or more medical service for his money, since the costly diagnostic equipment of a group is amortized by large volume at low per unit cost. Actual cash saving is often passed on to the patient.

The relatively higher ratio of certified specialists in a group has actually stimulated higher standards and quality of medical care in the surrounding community through the example set by the group.

Criticism and obstacles

Group practice is not without criticism. Some of its claimed advantages for physicians and patients are being attacked. Many physicians practicing alone insist that the special facilities of groups are wasted or poorly used. The ordinary solo practitioner has "adequate equipment" for the care of 85 percent of his patients. The unnecessary "through the mill" treatment of all patients would best be reserved for the care of the 15 percent of patients who require special consultation and diagnostic work-up.

Critics say physicians in group practice lose their exercise of independent judgment by over-referral to the consultants at their elbow. The professional stimulation of his fellow group physicians is outweighed, it is argued, by his loss of contact with colleagues outside the group.

The argument for highly qualified specialists and diagnostic laboratories is countered by the claim that these elements in a group are now generally available outside of groups in all areas with the possible exception of certain isolated rural regions.

There are real obstacles to the growth of group practice, which perhaps explains why approximately only 5 percent of practicing physicians in the United States are engaged full or part time in this mode of practice.

The establishment of a group requires a considerable capital investment for offices and equipment, especially if a group hospital is contemplated. Although lending institutions are more willing to lend money to a group of physicians than to an individual, and although the total investment for a group practice may be less than would be necessary if each doctor were to establish an individual office, such a venture as negotiating a large loan requires high caliber business acumen and leadership which is not always forthcoming. Physicians are not trained in business administration.

To establish a group, or even to evaluate the feasibility of joining an existing group, requires some fiscal, legal and administrative understanding.

One thing is pretty clear, since the opportunities for practical residency-type training in either solo or group practice are nonexistent, you who will make the choice between solo or group practice are generally unaware of the advantages and limitations of both. But of the two, you are probably more correctly informed concerning solo practice.

Success and failure

The most important element of success in group practice is the ability of a group to attract and keep *well qualified physicians whose personalities are suited to cooperative joint practice.*

A physician's training equips him to dominate the scene of his work. Consequently, some physicians in spite of residency training, are not suited in attitude to group effort and the teamwork practice of medicine.

Before considering a physician for a staff position, many groups invite the applicant *and his wife* for a social evening with a "selections committee." This is done in order to better evaluate the applicant's probable "fit" into the group as a person.

Once the staff pattern is set, creating a group of highly skilled and competent doctors, practicing as a team under one roof, it is tempting to new men of comparable professional integrity to join, and the group will likely succeed.

Income

The least contributory factor to failure of group practice is total group income. The recorded experience of now defunct groups is that they were able to practice reasonably good medicine, had adequate patients, and *group income* was sufficient.

The principal problem was income *distribution*.

Although this is the major difficulty in groups composed of 12-18 doctors, most other groups are faced with the problem to a degree.

In smaller groups, however, organizational problems predominate; in larger ones the struggle is for authority and control among members of executive committees and/or specialty cliques.

Not infrequently groups fail to keep good staff members because the advance from a junior partnership is either too slow or is blocked entirely.

Internal jealousies over volume of work, coupled with senior partnership status on the part of a low producer has sometimes pointed up the wide discrepancy in income based solely or primarily upon partnership level.

In the interest of all group physicians, most authorities are agreed that *junior partnership should proceed regularly and in a fixed time to senior status.*

Future

There is little doubt that group medical practice will increase in this country. Groups are becoming more common even in New England (many beginning as obstetrical partnerships) where the fewest groups existed before 1950. The trend is also toward larger groups, making them less vulnerable to the effects of the loss of one or two physicians. The experience of groups generally has been that larger groups in larger communities are most successful in surviving over extended periods.

Comprehensive

The fee-for-service method of payment for medical care has been partially supplanted by the establishment and growth of various plans employing the insurance principle. Budgeting for illness is a necessity, since the patient is faced with today's costlier — although more complete — medical care. In any one year almost half the nation's medical bill is shouldered by 10 percent of its population.

Underwriting the costs of medical care, to spread the burden and encourage the early and full use of comprehensive service by prepayment is clearly indicated, especially for families of low and middle income.[1]

Some say that prepayment for

1. Prepaid Group Practice Plans, A Listing by State. U. S. Dept. of Health, Education and Welfare, May 1958.

the costs of hospitalization, surgery, obstetrics and other limited services alone, although of considerable aid in meeting costs of expensive services, encourages the use of the costlier services and fails to employ the prevention incentive which is fostered when comprehensive care is insured.

If the ultimate goal of medical practice serving the individual is to employ all of the best techniques for prevention of illness and its sequellae, and accomplishment of this goal is bound up with the quality of medical care and its distribution, then group practice and prepayment for comprehensive medical care probably combine the elements which offer the best potentialities for the practice of preventive medicine and the fulfillment of this goal within our present knowledge of illness, its causes and its cures.

Questions

Before jumping into any group practice you would be wise to visit several groups, speak with the junior and senior members in your field of medicine. Explore the possibilities in those communities where you wish to practice.

Here are some questions you might concern yourself with when looking into a specific group:

1. How many years nas the group been in existence?
2. What is the composition of the group—by number and by specialty?
3. What hospital affiliations do group members have?
4. How many founding partners, junior partners, and employed physicians?
5. What has been the tenure of the physicians — both partners and employed physicians?
6. How many defections in the past few years? What status was held by the defected members? Why did they leave? Are there other groups in the area?
7. Is there a contractual formula for the length of time for succession to a senior or junior partnership? What are the financial terms in the interim? (Usual arrangement calls for salary during a trial or "apprentice period" of one year or less.)
8. What specific terms would call for the severance of a partner or probationary physician? What kind of a vote is required to separate a physician from the group? (Two-thirds or three-quarters is the usual.)

9. Does the group have a business manager? How long has he been employed by the group?
10. Are there any family ties between members of the group?
11. Finally, and you may determine this only through rather indirect and discreet sources, are there any social relationships among members of the group which you must share in order to "get along" with the group—or can you be reasonably free to pick and choose your own private mode of living outside office hours?

The elements of group practice described here should give you a basic understanding of its organizational pattern of medical services, and help you make a more informed judgment of it. The overwhelming weight of opinion being advanced at the present time clearly indicates that group practice is a growing element of medicine in our era, and that it will play an ever-increasing role in the development of higher quality, comprehensive medical care at the private practice level. However, the decision to become associated with an existing medical group or join in the establishment of a new one requires consideration of *all the practical matters in the particular opportunity.**

* A comprehensive survey of medical group practice in the United States is being conducted jointly by the American Medical Association, American Association of Medical Clinics and the National Association of Clinic Managers. The information thus gathered will update some of the material presented here.

Clinico–Pathological Conference

University of Louisville School of Medicine and University of Louisville Hospitals

A 63-year-old male reported to the ear, nose and throat clinic complaining of hemoptysis and hoarseness.

A brief note, recorded in the clinic at that time, stated that the hoarseness was of three months' duration, and had been accompanied by soreness of the throat during the past month. During the past few weeks the patient had coughed teaspoonful quantities of bright red blood approximately once a week. A direct laryngoscopy was performed and revealed the right cord to be fixed and roughened in the middle third. Two days later the lesion was biopsied and revealed a squamous cell carcinoma.

An x-ray of the chest, taken at the first clinic visit, showed a mass in the upper lobe of the left lung with the possibility of cavity formation.

The impression from the roentgenograms at that time was that the lesion probably represented tuberculosis, but the possibility of tumor could not be ruled out.

Admission

The patient was admitted to the hospital and gave the same history as that obtained in the ear, nose and throat clinic, with the addition that he had noted wheezing over a period of three months. There had been no night sweats. He had lost 15 pounds even though his appetite had remained good. He smoked approximately 5 cigarettes a day for the past 5 years and took only an

occasional drink of alcohol. There was neither a history of tuberculosis in the family, nor of any contact outside the family.

Physical examination revealed diminished breath sounds over the left apical region of the chest. Otherwise all recorded findings were within normal limits, with the exception, of course, of the fixed right vocal cord. None of the examiners could find palpable cervical lymph nodes.

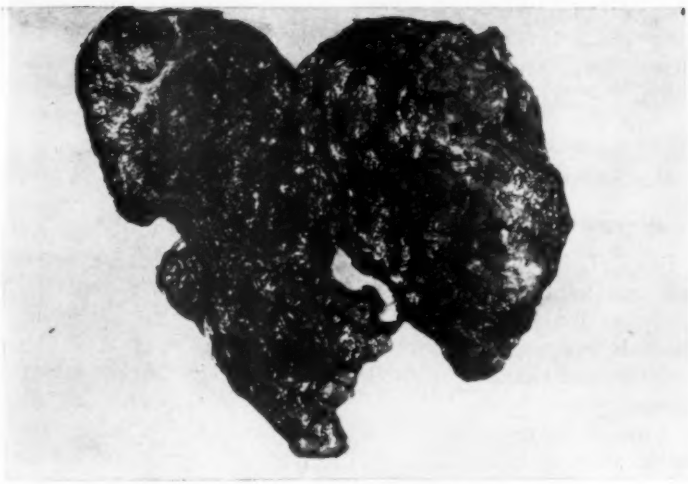
A repeat chest x-ray showed no essential change over the previous one, and the interpretation was the same. Histoplasmin and O.T. skin tests were both positive in unrecorded dilutions. Three acid-fast smears and cultures of sputum were negative. A.V.D. R.L. was negative. Hemoglobin was 14.8 grams, white blood count 6600, with a differential of 47 polymorphonuclear leukocytes, 51 lymphocytes, 2 eosinophilic leukocytes. Hematocrit was 44.

Four days after admission an operation was performed.

Discussion

DR. GROVER B. SANDERS: The problem presented in this case is that of a 63-year-old male with a proven cancer of the larynx and a mass in the left upper lobe with questionable cavitation. The significant complaints are hoarseness of 3 months' duration, soreness of the throat of one month duration, wheezing respirations, and a 15 pound weight loss in the presence of a normal appetite. We are not told whether the wheeze was localized or generalized.

It is difficult on the basis of the information available to know whether certain of the symptoms resulted from carcinoma of the larynx or from the chest lesion. For the sake of discussion I will assume that the hemoptysis and wheeze were produced by the mass in the left upper lobe. If this be true then our first consideration would be bronchogenic carcinoma. A 63-year-old male, even one who is not an excessive smoker, presenting a mass lesion in the lung with a wheeze and hemoptysis is very likely to have a bronchogenic carcinoma. The physical findings are not of any diagnostic value since they could be produced by a space occupying lesion of most any type. Bronchial aspiration and examination for cancer cells would ordinarily be very valuable in establishing a diagnosis, however, in this case with a proven carcinoma of the larynx, interpretation of a positive report would indeed be hazardous.



Gross photograph showing bisected mass in apex of lung.

Tuberculosis was considered and cannot be excluded at this point. This could very well be a tuberculoma that has shelled out. Under such circumstances I would expect the sputum to show acid-fast bacilli which was not the case. For this reason I suspect that this was not tuberculosis.

Fungus

Fungus infection must also be considered. Blastomycosis, a relatively common fungus infection in this area, frequently produces a mass lesion and cavitation may occasionally occur. Usually the lung lesions are more diffuse and one can demonstrate extrapulmonary lesions, particularly osseous and cutaneous, and less commonly genitourinary and central nervous system lesions.

Other less frequently encountered fungus infections such as coccidioidomycosis and aspergillosis may produce such a mass lesion. Histoplasmosis is more likely to demonstrate an x-ray picture of fibrosis or infiltration than a mass.

If this were fungus infection, particularly blastomycosis, we would have expected the patient to have been febrile and to have more cough and constitutional

symptoms than was the case. For these and other reasons noted above I doubt that this is a fungus lesion.

I still favor the possibility of bronchogenic carcinoma.

May we see the x-ray films?

X-ray report

DR. J. T. LING: Postero-anterior and left lateral teleroentgenogram and planigram of the chest showed a normal cardiac silhouette and moderate bilateral pulmonary emphysema.

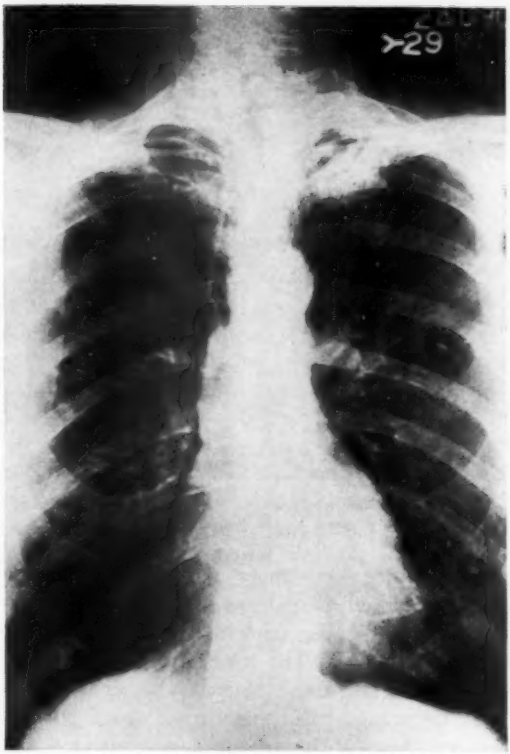
A thin-walled cavity, about 5.0 cm in diameter is noted in the superior portion of the apico-posterior segment of the left upper lobe. Within the cavity, and almost entirely capped by a thin crescent of air, is a solid mass 4.0 cm in diameter. Linear fibrotic appearing strands radiate laterally from the apex of the left hilus toward the cavity.

The roentgen finding of a smooth, rounded mass in a thin-walled cavity is believed to be sufficiently distinctive to warrant the diagnosis of intracavitary fungus ball (aspergilloma). Hemoptysis in a healthy person affords evidence supporting this opinion. Unfortunately, this case is complicated by the presence of a laryngeal carcinoma.

These characteristics virtually eliminated from consideration such cavitary diseases as acute and chronic pulmonary abscess, necrotic tumor, and liquefied infarcts. Pulmonary hydatidosis will simulate the appearance of a fungus ball only during its intermediate stage. An inspissated blood clot in an abscess cavity, in contradistinction to a fungus ball, is generally associated with relative extensive disease in the surrounding parenchyma.

DR. SANDERS: The x-ray appearance is not what we had anticipated from reading the protocol. As pointed out by Dr. Ling, rather than being the usual appearing cavity as one sees in many types of pulmonary disease, this lesion consists of a so-called intracavitary ball surrounded by a thin crescent of air. This x-ray picture has been said to be pathognomonic of primary pulmonary aspergillosis. Some nine such cases had been reported prior to July 1956.

If we exclude the x-ray findings we would still make a presumptive diagnosis of bronchogenic carcinoma and recommend surgery. However, in view of the x-ray we are forced to change our diagnosis to primary pulmonary aspergillosis. All of this patient's chest symptoms can be explained by an aspergilloma. Hemoptysis



P. A. teleroentgenogram

is a frequent finding, as is cough and a wheeze.

The operation was probably a thoracotomy followed by lobectomy, which is the treatment of choice for primary pulmonary aspergillosis when the lesion is localized.

Pathology

DR. WM. M. CHRISTOPHERSON: Thank you, Dr. Sanders and Dr. Ling. I must say this case seems much more clear cut now than it did when the patient was admitted with the combination of laryngeal carcinoma and a soli-

A. P. laminagram

tary lung lesion. The question raised then, in addition to those that have been previously discussed, was whether or not the lung shadow could represent a metastasis from the laryngeal carcinoma. The patient was therefore referred to the Tumor Board. We felt that this was probably quite unlikely, since the cancer of the vocal cord appeared to be a relatively early one, and since there were no demonstrable cervical lymph nodes. The Board did feel, however, that a definite diagnosis should be established and, therefore, recommended thoracotomy precede laryngectomy. Accordingly the patient was explored and a left upper lobectomy was performed.

The lobe weighed 300 grams and contained a rather large palpable mass in the apical portion. The specimen was bisected and revealed a thin-walled cavity approximately 5 cm in diameter. This cavity communicated with a large bronchus which appeared to be completely patent. The cavity contained a soft, brown mass of amorphous material. We gave the surgeons a diagnosis of fungus ball and the chest was closed.

On histologic examination the mass consisted of numerous

branching hyphae. These were periodic acid-Schiff positive. The mold was confined entirely to the lumen of the cavity and no organisms were found in the cavity wall, or elsewhere in the lobe. Culture of the material revealed *aspergillus*.

The cavity was lined in part by bronchial epithelium and in part by granulation tissue. There was moderate inflammatory infiltrate in the wall consisting largely of plasma cells and lymphocytes. The remainder of the wall consisted of a rather thin layer of fibrous tissue. There was no granulomatous reaction within the wall or the surrounding lung parenchyma. The remainder of the lung was entirely normal.

It was our impression that the cavity represented a bronchiogenic cyst which had provided a nice culture media for the mold to grow in. The patient made an uneventful recovery and two weeks later a laryngectomy was performed. Postoperative sputum cultures consistently failed to reveal aspergillus.

We would like to have had a better history on this patient, especially the man's occupation. Although aspergillus is very prevalent in both plants and animals, aspergillosis seems to be more commonly found in people who work with grains, or are exposed to grain dust. As early as 1856 Virchow described the pathogenicity of aspergilli in pigeon feeders in Paris.

It is generally conceded that aspergillomas occur in previously existing pulmonary lesions, such as the bronchiogenic cyst that this patient demonstrated. So far as I know all cases reported have involved either the upper lobe of the lung or the superior segment of the lower lobe. In addition to the localized form demonstrated in our patient there have been cases described with nodulations of both lungs and with a chronic granulomatous response to the mold.

Guest Editorial

The History of Surgery

A phase of surgical education all too often neglected is that related to the cultural and historical aspects of surgery. This I believe to be true in many residency programs.

Of all men in the learned professions, the surgeon should be comparable in his cultural and historical background with the clergyman and the practitioner of the law. Chiefs of services, who are entrusted with the education of the surgeon, should find time to encourage their residents in the study of the heritage of surgery and aid in the broadening of their surgical horizons. Surgical residents should be taught the great surgical truths as exemplified in the lives and labors of surgeons who through the years contributed to the basic knowledge which they now aspire to acquire.

There is no clear reason for residency programs fostering mere hewers of bone and flesh or drawers of blood. Many residents speak freely of their preference for a Billroth I or a Billroth II procedure in gastric resection, but how much more interesting and meaningful their discussion might be in a knowledge of the life of Billroth. He was one of the great pathologists

D. P. HALL, M.D.,
Associate Professor
of Surgery,
University
of Louisville
School of Medicine

of his time, a musician of repute, a friend of Brahms and Hanslick, and the surgical father of Eiselsberg and Winiwarter.

All of us are hero worshipers consciously or subconsciously; all of us have a surgical idol and this is good because it may make us wish upon a star and raise us above the norm.

We may gain much from studying the lives and works of the surgeons of England and Scotland—Lord Moynihan of our generation was unexcelled in his surgical technic while his cultural attainments made him a model for all writers of surgical works because of his pure style of English. It was he who said, "Surgery is not only a matter of operating skillfully, it must engage in its service, qualities of mind and heart that raise it to the very highest pinnacle of human endeavor."

The trials and triumphs of Joseph Lister in originating antisepsis are a part of our common heritage. Lawson Tait, he of the Staffordshire knot and master pelvic surgeon, introduced asepsis without recognition. Syme, Robert Liston, Macewen, Victor Horsley, Astley Cooper, Abernethy, Bland Sutton and Grey Turner are a few British surgeons whose surgical careers may be valuable to study.

To know the history of German surgery is to find where our methodical routines in hospitals had their inception. The resident should acquaint himself with the lives of Bergmann, Trendelenburg, Hacker, Mikulicz, Czerny, Volkmann, and a host of others who wore robes of scarlet.

The romance of American surgery has been per-

meated with enthusiasm from its early beginning. There is not one among our surgical guild who on reading of America's first successful attempt in the field of abdominal surgery is not stirred by high adventure. Read "Three Cases of Extirpation of Diseased Ovaria" done in 1809 by the immortal Ephraim McDowell of Kentucky, father of abdominal surgery.

The life of Samuel David Gross should be known to every resident. He was the author of the first all American textbook of surgery, the material for which he collected while professor of surgery in the University of Louisville and later at Jefferson Medical College.

"The Story of My Life," by J. Marion Sims, who first cured vesicovaginal fistula (1849) after 29 failures, should be a lesson to the resident in perseverance and triumph. He operated upon the Empress Eugenie at St. Cloud and became surgeon to the beauteous Duchess of Hamilton.

Read of Joseph Pancoast, the dexterous, the dramatic American surgeon with a hand said to have been as steady as a rock but as light as a floating perfume, with a heart that was a stranger to fear, and an eye as quiet as a flashing sunbeam.

Peruse the writings of Benjamin Winslow Dudley who, virtually single handed, founded the first medical school west of the Alleghenies, Transylvania, and did 225 lithotomies with only 3 deaths (1800).

The name of William Stewart Halsted is known to many residents, but to know his gentleness, eccentricities, inventiveness and mastery of historical surgical literature may give you a great lift and introduce you to this master surgeon who established the surgical residency system and was first to use the rubber glove.

The contributions of many who held Fellowship in the School of Surgical Prophets may be studied with

gain—John B. Murphy, Allen Kanavel, The Mayos, Matas, W. D. Haggard, Lahey, Abell, Evarts Graham and Fred Rankin. These are but a few whose lives have made the cultural and historical aspects of American surgery rich; all were animated with a deep sense of responsibility to the historical background of our surgical heritage.

One of the present threats to surgical education is a tendency for surgical residency programs to become operative trade schools with emphasis on the mechanics of surgery. The art, logic and culture gained in part from studies in the history of surgery has been all but lost.

"Is the buyer in?"

One of a series o

University of Louisville Medical Center

With a house staff of nearly 150, this center offers training in 14 specialties through five hospitals affiliated with the University of Louisville Medical School.

Jointly developed by the University of Louisville and the City of Louisville, the Louisville Medical Center occupies a giant, 20 acre tract near the downtown area.

The center includes the Schools of Medicine and Dentistry, Louisville General Hospital, Children's Hospital, Jewish Hospital, Methodist Evangelical Hospital, and a new five story clinical research building.

The University of Louisville was established in 1798 and the School of Medicine chartered in 1833. The medical school was organized by a group of professors from Transylvania Medical School, the oldest west of the Allegheny Mountains. Among the first professors were Samuel D. Gross, Austin Flint, Sr., Daniel Drake, Charles Caldwell, Henry Miller and Lunsford P. Yandell, Sr. It is the oldest municipal university in the United States.

ries o eading medical centers

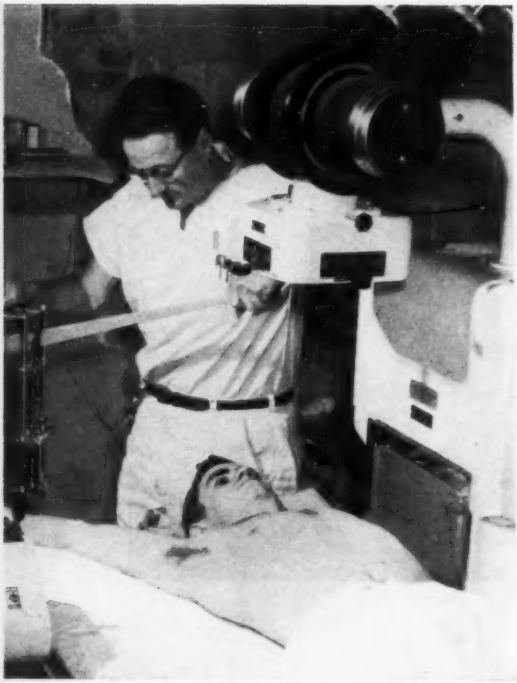
Faculty

The faculty of the School of Medicine consists of 103 full-time and 396 part-time members who supervise the clinical teaching program.

The medical school receives more than $1 million annually in separate grants for several projects and the furthering of teaching.

The University of Louisville School of Medicine Library was established in 1837 when Joshua Barker Flint was sent to Europe to buy books and equipment for the then infant school. As a consequence, the library is the repository of some of the most rare books on medicine and physical science to be found in the United States. Housed in a modern wing with workshop and a fire proof area for rare books and manuscripts, the library contains more than 37,000 books and receives some 795 medical periodicals.

The library maintains a branch



Here, patient is being readied for rapid sequence x-ray.

in the Louisville General Hospital for the use of house officers in the University of Louisville Hospitals.

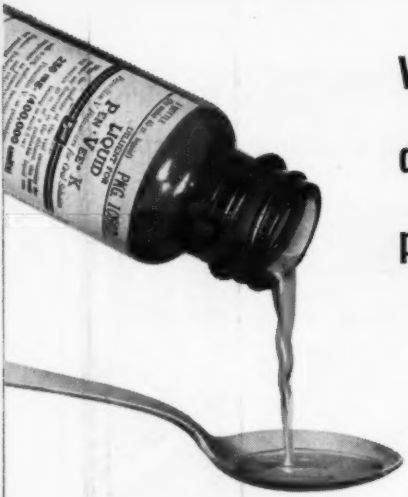
General Hospital

Louisville General Hospital is the oldest teaching hospital in continuous operation west of the Alleghenies. Established in 1817, it is the nucleus for the clinical teaching of third and fourth year students and the center of the residency program. The house staff consists of nearly 150 residents and interns, some of whom rotate through affiliated institutions. With more than 400 beds, General Hospital draws from a population of 600,000. The outpatient clinic treats 125,000 annually in addition to 75,000 visits to the emergency rooms.

Now nearing completion is a

Busy Residents

at Louisville Children's Hospital



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	3rd. Yr.	$1,893
	4th. Yr.	$2,520
Medicine	1st. Yr.	$1,574
	2nd. Yr.	$1,893
	3rd. Yr.	$2,520
Ob—Gyn	2nd. Yr.	$1,260
	3rd. Yr.	$1,893
	4th. Yr.	$2,520
Pediatrics	1st. Yr.	$1,000
	2nd. Yr.	$1,893
	3rd. Yr.	$2,520
Psychiatry	1st. Yr.	$2,520
Radiology	1st. Yr.	$1,000
	2nd. Yr.	$1,893
	3rd. Yr.	$2,520
Pathology	1st. Yr.	$1,893
	2nd. Yr.	$3,000
Dental Resident		$2,041
Neurology		$2,600

$4 million wing for new departments of pathology, radiology, obstetrics and surgery. Fourteen operating rooms are included in the addition.

A School of Nursing is maintained, affiliated with the University of Louisville, with an average enrollment of 100.

Children's

The Children's Hospital, located opposite the General Hospital, was incorporated in 1890. Its facilities are an integral part of the medical school teaching and residency program. The chairmen of the departments of pediatrics and surgery assume the responsibilities for the services in this hospital. The capacity is 200. A clinical amphitheater seating 100 is in the center of the hospital and available for all teaching.

Jewish Hospital

Erected 3 years ago, adjacent to the Louisville General Hospital, the modern, 120 bed Jewish Hospital is an important unit in the student teaching and residency programs. The hospital contains a 70 seat lecture room for resident conferences. Construction is expected to begin soon to expand bed capacity to more than double the present figure.

Training

All patients in the Louisville General Hospital are house patients, and about 55 percent of the patients at Children's Hospital are under house staff care. The Jewish Hospital maintains a service for private patients but a

UNIVERSITY OF LOUISVILLE HOSPITALS
CONFERENCES

MONDAY

8:00 to 9:00	Surgical Staff Rounds
9:00 to 10:00	Resident-Staff Conference (Medicine)
8:30 to 10:30	Neurology Grand Rounds
1:00 to 2:00	Mortality Conference (Medicine)
3:00 to 4:00	Death Conference (Surgery)
4:00 to 5:00	E.E.G. Conference
4:00 to 5:00	Surgical Grand Rounds

TUESDAY

8:00 to 9:00	Surgical Staff Rounds
8:00 to 9:00	Full Time Staff Conference (Medicine)
9:00 to 10:00	Resident-Staff Conference (Medicine)
11:30 to 12:30	Neurosurgery Conference
12:00 to 1:30	Cardiovascular Conference
3:00 to 5:00	Anesthesiology Conference
4:00 to 5:00	Neurology Conference

WEDNESDAY

9:00 to 10:00	Resident-Staff Conference (Medicine)
12:30 to 1:30	Gastroenterology
4:00 to 5:00	Neurology

THURSDAY

8:00 to 9:00	Surgical Staff Rounds
9:00 to 10:00	Resident-Staff Conference (Medicine)
12:00 to 1:00	Clinico-pathology Conference
4:00 to 5:00	E.E.G. Conference
3:00 to 5:00	Anesthesia Seminar

FRIDAY

8:00 to 9:00	Surgical Staff Rounds
9:00 to 10:00	Resident-Staff Conference (Medicine)
11:00 to 12:00	Neurology Journal Club
11:00 to 12:00	X-ray Conference

SATURDAY

8:00 to 9:00	Surgical Clinical Conference
9:00 to 10:00	Medical Clinical Conference
9:00 to 10:00	Chest Conference
10:00 to 11:00	All Service Conference

UNIVERSITY OF LOUISVILLE HOSPITALS

	CHILDREN'S	JEWISH	LOUISVILLE GENERAL
Patients Admitted	7,474	6,383	10,828
Number of Hospital Days	48,297	42,053	114,574
Outpatient Visits	10,108	6,921	214,664
Births		956	2,694
Surgical Procedures	3,503	3,948	4,684
Anesthetics	3,495	3,716	4,769
Pathological Examinations	1,320	2,567	3,787
			(438 autopsies)
Laboratory Examinations	52,025	62,577	240,862
X-ray Examinations	8,579	7,352	30,391 patients
			41,387 examinations
			87,803 films
			4,466 treatments

RESIDENCY PROGRAMS

SERVICE	CHIEF OF SERVICE	RESIDENTS IN 1st YEAR	TOTAL RESIDENTS IN PROGRAM	PROGRAM IN YEARS
Anesthesiology	Eugene H. Conner	3	7	2
Internal Medicine	Beverly T. Towery	8	18	3
Neurology	Ephraim Roseman	2	5	3
Neurosurgery	R. Glen Spurling	2	5	4
Ob.—Gyn.	Douglas M. Haynes	3	9	3
Ophthalmology	C. Dwight Townes	1	4	3
Orthopedic Surg.	K. Armand Fischer		3	4
Otolaryngology	William C. Wolfe	1	4	2
Pathology	Wm. M. Christophersen	2	10	6
Pediatrics	A. J. Steigmen	9	23	4
Psychiatry	Wm. K. Keller	5	13	3
Radiology	Everett L. Pirkey	3	9	4
Surgery	Rudolf J. Noer	7	19	4
Urology	Robert Lich. Jr.	2	6	3

Above, waiting room of LGH outpatient department. More than 200,000 patient visits are made here each year. Right, test being made in radioisotope laboratory.

great percentage are marked as teaching cases and residents on rotation share some responsibility in their care.

The resident in the University of Louisville Hospitals shares an increasing responsibility in the care of patients during his residency, and during his last year assumes major responsibility for his assigned cases.

Residents are rotated through Kosair Crippled Children's Hospital and Waverly Hills Tuberculosis Sanatorium services as a part of their special training.

Single house officers have furnished quarters and rooms are

provided for married residents when on duty. Housing for married house officers is available in the general environs of the Medical Center; the chairman of the house officers committee provides help in obtaining suitable living quarters.

Hospitalization is available to house officers and their families, including private institution care.

The Ohio River offers swimming and boating. Many natural wooded parks are a part of Louisville. Swimming pools, golf courses, and tennis courts are all within a short distance of the Medical Center.

The Louisville Orchestra, J. B. Speed Art Museum, Kentucky Derby and spring and fall racing at Churchill Downs are among the varied diversions offered in the Louisville area.

For additional information on the residency programs, write to the chief of the service in which you are interested.

FELLOWSHIPS OPEN

Three fellowships in human ecology have been established by Cornell University Medical College. Part of Cornell's Human Ecology Study Program, under the direction of Dr. Harold G. Wolff, the two-year appointments are for men planning academic careers and who have completed one or more years of postgraduate training in internal medicine, neurology, psychiatry, preventive medicine or public health. Stipend is $4500 the first year, $5000 the second with an additional $500 a year for each dependent. The program staff includes representatives from internal medicine, psychiatry, neurology, psychology, sociology, and cultural anthropology. Fellows will participate in field observations of groups drawn from the general population of "healthy" persons, take part in the long-term observation and care of outpatients, and make use of laboratory facilities for the study of behavior and of processes relating to the functions of various organ systems. To make application, write Dr. E. Hugh Luckey, Chairman, Department of Medicine, New York Hospital—Cornell Medical Center, 525 E. 68th St., New York 21, New York.

How the Medical Subspecialties Are Taught at My Hospital

Through a planned, step-by-step rotation, the general internal medicine resident can become familiar with technical procedures, learn to approach specific medical problems from the subspecialist's viewpoint.

Donald A. Adams, M.D.

The teaching of the subspecialties of internal medicine to medical interns and residents is an essential part of a good hospital teaching program. What to emphasize, when to emphasize it, and how to present the program are important problems of concern to both the prospective internist and his chief of service. The resident wants a well rounded but thorough program; the department head must plan an interesting but practical system utilizing available teaching facilities.

Progression

The beginning medical house officer often asks, "when will I learn how to read these EKG's?" Or, "will I ever be able to interpret a bone marrow smear? "How do I evaluate the results of this ACTH stimulation test?" These and similar questions signify a curiosity in wanting to know as much about the ins and

outs of the various medical subspecialties as quickly as possible.

Practically speaking, however, there should be a progression of exposure to them as the resident's training advances. A reasonable plan, I believe, is sort of a logarithmic progression in teaching him the medical subspecialties. Starting as a medical intern there should be some experience with them, but not extensive. Basic concepts of general internal medicine must be formulated initially. As the resident becomes more and more advanced in his training, he receives increased exposure to the subspecialties, until the major part of his training is exclusively involved with them.

Perhaps there is no single program which can claim to be "best." Many hospitals have excellent programs for the teaching of the medical subspecialties, yet differs from one another in many respects. I would like to present the program that is now being followed by the Department of Medicine at the University of California at Los Angeles Medical Center, a hospital where I have had most of my medical training.

This center, now in its fourth year of operation, is a 350 bed university hospital having straight internships and an extensive residency training program.

The medical service consists of 110 beds (including student health service beds) with 2527 medical admissions last year, a large medical outpatient department with 20,116 medical patient

About The Author

With an A.B., M.A., and M.D. (1955) from the University of California at Los Angeles (member of UCLA's first medical school class), the author interned at UCLA Medical Center, followed by an assistant residency year at Strong Memorial and Municipal Hospitals, Rochester, N. Y. Returning to UCLA as an associate resident for one year, he is at present senior resident in medicine and fellow in metabolism at VA Hospital, Los Angeles. Recipient of the American College of Physicians-Mead Johnson Residency Scholarship (1958-59), Dr. Adams has authored two articles on Agranulocytosis published in the *Annals of Internal Medicine* (2-58) and in the *Journal of the American Medical Association* (7-58).

visits annually, and an active emergency room.

The medical house staff consists of 12 interns, 6 assistant (first year) residents, 4 associate (second year) residents, a chief resident, and various Fellows in several subspecialty departments. There are one or more full-time teachers of the School of Medicine in all the major subspecialty fields.

Intern participates

The medical intern training is mostly in general internal medicine. He does, however, begin to become acquainted with the various subspecialty departments and to interpret or do many of the techniques utilized by those services.

On the wards, during rounds by a subspecialty team, the intern participates in the discussion of the diagnostic and therapeutic plans on his patients. He often does specialized techniques under supervision of the subspecialty resident, such as bone marrow aspirations, skin biopsies, sigmoidoscopies, joint aspirations, and other procedures.

He may assist on his patients with more involved procedures such as cardiac catheterization, pulmonary function tests, gastroscopies, liver or renal biopsies, artificial kidney or peritoneal dialyses.

In the medical outpatient clinic, the intern follows his own patients throughout the year spending the half-days weekly in the clinic seeing new and return patients. This plan was instituted to attain continuity between patient and doctor. It allows the doctor opportunity to follow the course of a disease more completely and gives the clinic patient a feeling that he has his "own doctor" who understands all his problems.

Consultant

When consultation for a particular subspecialty problem arises, the intern presents his patient to the consultant of the desired subspecialty clinic.

When possible the intern carries out any diagnostic or therapeutic suggestions and continues to see the patient with the specialist as long as is needed.

When assigned to the emergency room the intern often calls upon the subspecialty resident or consultant to help him with a problem. The dermatologist may advise him in the differential diagnosis and treatment of an acute, pruritic papular rash. The neurologist may recommend management of a patient with status epi-

lepticus. The endocrinologist may be called to consult on the handling of an adrenalectomized patient in Addisonian crisis.

During such associations and discussions with the medical subspecialist, the beginning house officer is learning to acquire some of the skills and techniques that are peculiar to each of the separate subspecialties, but which together make up the field of internal medicine. Thus the foundation is laid for more intensified subspecialty education in subsequent years.

The training of the assistant (first year) resident also emphasizes general internal medicine, but his training in the subspecialties is considerably expanded. Eight months of the year are spent on the medical wards where he supervises a ward service with two interns and medical students. Here he has contact with the subspecialists when consultations are requested on his service. He usually attends rounds and conferences of these groups when they are on his ward.

In the general medical outpatient clinic his program is similar to that described above for the intern; he follows his own patients throughout the year, two half-days weekly.

Clinic subspecialist

For two months the assistant resident is assigned as the clinic subspecialty resident. This has proved a very popular period. He attends all medical subspecialty clinics—allergy, arthritis, cardiac, chest, diabetic, metabolic-endocrine, gastrointestinal, hematology, and renal-hypertension. At each of these he sees patients referred for consultation. He examines, does various procedures, and manages or makes recommendations to the referring physician after discussion with the attending specialist. Most of the attending consultants are full-time faculty and all are board certified in their respective fields.

Conferences

Teaching conferences, where new or interesting cases are presented and discussed, are incorporated into most of these clinics. This is an especially valuable teaching aid since all those working in the clinic are able to see several interesting patients and not just the cases in which they are directly involved.

The assistant resident is responsible for reading all the adult electrocardiograms for the hospital for a two month period. He reviews each tracing daily with a cardiologist who teaches him the

finer points of electrocardiography.

During this same period the assistant resident supervises the emergency room medical service. Here he sees patients for disposition or admission after examination by the medical intern. He takes medical consultations on surgical patients in the emergency room, and he calls for subspecialty advice when such is needed.

At this juncture the resident has attained a good knowledge of the general scope of internal medicine and has developed a basic understanding of many of the problems seen in the subspecialties. He next receives more intensified concentrated subspecialty teaching.

Rotation

The associate (second year) resident is known as the "rotating subspecialist" of the medical service. For three months of the year he serves as the head resident of the medical outpatient department and admitting officer for the inpatient medical service. During this time he is able to attend and participate in several of the subspecialty clinics and does a considerable amount of teaching to the medical students in the clinic.

The rest of the year he spends three months on each of three subspecialties of his choice. The services from which he may choose include: cardiology, dermatology, gastroenterology, hematology, infectious diseases, metabolic-endocrinology, neurology, pulmonary, or other special programs that may be arranged.

Each subspecialty group has a planned and varied program for its "resident." He is responsible for the smooth running of that service in the hospital, and his duties generally do not overlap those of a fellow or junior instructor.

The associate resident makes consultations requested on all non-private patients in the hospital. Pre- and post-op surgical patients are often followed closely for a subspecialty problem. Problems of diabetic management, the care of the adrenalectomized or hypophysectomized patient, or the medical management of special cardiac surgery patients are typical cases seen on the surgical wards.

All patients seen on the medical or surgical floors are presented by the associate resident on rounds of the subspecialty group two to three times weekly. These rounds are attended by one or more full-time professors of that subspecialty department,

fellows, "visiting firemen," house staff, and other interested persons. It often makes quite a formidable gathering. These rounds unquestionably offer the resident an outstanding opportunity to learn the complexities of a particular subspecialty.

Technical training

In this program the associate resident has no direct ward patient care responsibilities; he makes recommendations through consultation. However, he attends the clinic or clinics of that subspecialty where he sees and manages patients weekly. He often continues following patients whom he has seen in consultation when they were in the hospital.

The subspecialty resident is taught various specialized techniques. On hematology he reads the bone marrows with review and teaching by the pathologist, he can assist with special erythrokinetic studies using radioisotope techniques. On cardiology he assists the fellow with cardiac catheterizations, he does arterial pulse tracings, vectorcardiograms. Endoscopies and biopsies may be done on the GI service; on endocrinology he may do the radioactive iodine uptake tests, to name a few.

Exposure to such special procedures serves an excellent teaching function in familiarizing the resident with technical aspects unique to each subspecialty, even though the resident may not utilize them all in his future practice.

The associate resident may be called upon to give lectures to student nurses, or to assist in the teaching of medical students. Preparation for such talks further aids in the learning of a subspecialty. Conferences and clinics at other local hospitals are available to the subspecialty resident, thereby broadening his experience. For example, at the University Endocrine Clinic a high percentage of hyperthyroidism with few cases of myxedema are seen. However, at Harbor General Hospital Endocrine Clinic (a county hospital which serves for supplementary teaching) myxedema cases are prevalent with less Grave's disease seen.

Research

Original investigative work often intrigues the resident. In the UCLA Center program the associate resident has an opportunity to do small research projects in any subspecialty field he may desire. During my year as associate resident (just completed) I was fortunately able to partici-

pate in a few projects which I found quite stimulating.

One project was the evaluation of various methods of determining vitamin B_{12}-Co^{60} absorption in normal and anemic patients using the radioisotope scintillation equipment. Another project was the clinical evaluation of a new highly purified thyrotropin preparation on how it affects the radioiodine uptake by the thyroid in normal subjects and on the thyroid release curve of a hypophysectomized panhypopituitary patient.

I found this year particularly valuable from the aspect of learning the essential details of several medical subspecialties. Unfortunately there is not enough time in one year to spend equal time on all. Probably an additional year on a different group of subspecialties would be ideal.

I do believe, however, that three months in a particular subspecialty at this stage of training is the *minimum* period that should be allotted. I found that it took about two months to "learn the language" of a subspecialty, to learn something about the specialized tests, and to familiarize myself with the kind of problems seen. During the third month I was then able to apply these facts and have some feeling of confidence in handling situations seen in that field. I do not imply that the resident can be considered a full-fledged subspecialist with but three month's experience, but at least he is taught how to properly *approach* any problem from the subspecialist's viewpoint.

Fellowships

The third or fourth year is generally a fellowship program, with the entire year spent in a single subspecialty. At present there are fellowships available in cardiology, gastroenterology, hematology, metabolic - endocrinology, and neurology. Others will be developed in the future. Fellowships generally pay better than a regular residency and are favorable from this aspect.

The fellow has varied duties and opportunities. A research project or projects are usually done. This gives the fellow further experience in original research and usually authorship of one or more papers. He works in conjunction with the associate resident, supervising or teaching him, or he may perform some of his duties when there is no associate resident on that service.

The fellow learns to do involved techniques used in his subspecialty and performs these

throughout the year. For instance, in cardiology he does the cardiac catheterizations, vectorcardiograms, treadmill exercise tolerance tests; on metabolic he does renal biopsies, artificial kidney or peritoneal dialyses, thyroid radioiodine uptake counting; or on gastroenterology he performs gastroscopies, liver biopsies, and the like.

This year prepares the training internist for emphasis of a particular subspecialty in his practice, or with additional work can lead to an academic or full-time subspecialty career.

There are several methods to teach residents the intricacies of the medical subspecialties. A good teaching program stressing the subspecialties during some phase is very important in preparing him for the practice of internal medicine. Most teaching hospitals have effective and similar programs which vary by type, time, and degree of exposure to the several subspecialties.

The program as presented at this one university hospital is a well planned, graduated teaching program, probably most unique in its second year or associate resident level. Here an adequate period of time with excellent teaching is given on subspecialties of the resident's choice. He has independence to do the things he wishes to stress and has extensive facilities with which to work. He learns both from the experience of his seniors and by teaching his juniors.

The Physician Who Talked Himself Into Trouble

A physician's chance remark or ill-considered explanation to a patient can sometimes boomerang.

John A. Ewing, M.D.

Dr. Barber has never been sued for malpractice—but I can remember one time a few years ago when he came awfully close. And all because he didn't know when to stop talking.

His was the usual slow beginning, setting up a general practice in a small town, most of his patients in the early days coming from the poorer families in the community. Gradually he began to see an occasional patient from among the wealthier people in town. And he felt sure he'd really arrived when Mrs. Reed brought her youngsters to him. Mr. Reed owned one of the town's main industries and his wife was an acknowledged social leader.

The Reed children were fine physically but were due for a booster dose of vaccine. Dr. Barber administered the injections personally. Unfortunately, both children developed a local reaction, one fairly minor, the other rather severe; it worried Dr. Barber for several days.

He visited the home twice to see the children and each time he talked at length to the mother. And that's where he began to talk himself into trouble.

"I just can't understand it," he said repeatedly. "It was new vaccine and I'm *sure* everything was alright."

Mrs. Reed was worried, too, but not as much as Dr. Barber and anyway she could see that the children were getting better.

The trouble was that Dr. Barber felt a real need to vindicate himself in Mrs. Reed's eyes. A week or so later he met her in the country club and started up again. "I just can't understand what happened," he said.

Up to this point Mrs. Reed hadn't really wondered too much if such reactions were unusual or not. Mr. Reed had laughed it off saying that he had a much worse arm with typhoid shots during the war.

But Dr. Barber's protests were beginning to tell on Mrs. Reed.

What really put the lid on things was a week or so later when, after church, Dr. Barber made a point of walking over to Mrs. Reed:

"I've used that same bottle of vaccine on several other children and none of *them* had a severe reaction."

Dr. Barber hadn't stopped to think about just exactly what comfort this message was supposed to offer Mrs. Reed. Actually she was surprised to learn that her children's vaccine could be shared with other children. She had rather supposed she was paying for a personal bottle for her own children!

Later on she told a neighbor that she wondered why Dr. Barber would *risk* giving the vaccine

About The Author

Born and educated in Scotland, the author was graduated from the School of Medicine of the University of Edinburgh in 1946. Beginning a psychiatry residency in England in 1947, he received the University of London's Diploma in Psychological Medicine in 1950. Coming to the United States in 1951, he worked in a state hospital as senior physician, and as psychiatrist in North Carolina's Alcoholic Rehabilitation Center for three years.

Author of papers in several psychiatric journals and in the *New England Journal of Medicine, British Medical Journal, Medical Economics, Medical Times,* and others, Dr. Ewing is presently assistant professor of psychiatry, University of North Carolina School of Medicine, and director of the psychiatric inpatient service, North Carolina Memorial Hospital.

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to other children if he felt they too might get bad arms.

Thus, from the way he talked, Mrs. Reed felt that Dr. Barber's handling of the situation must somehow have been wrong. She changed doctors.

Dr. Barber has more experience now. He regrets losing the Reeds as patients as well as the friends and neighbors they might have brought him. Too late he realized that a more casual approach about the children's reactions would have been better. Now, if he had another chance, he'd take a more positive approach:

"This is common. It's a local reaction — possibly caused by their hypersensitivity, Mrs. Reed. They'll be alright soon."

Actually Mrs. Reed was told something like this by Dr. Williams (to whom she switched). She quite liked the idea of her children's sensitivity and she certainly never thought of suing Dr. Barber. She soon forgot about the unfortunate episode of the sore arms and that was that from her point of view.

Dr. Barber, though, learned a lesson the hard way and has never dared to forget the time he talked himself into trouble.

"Your sponge and needle counts are correct, doctor, but one of the student nurses is missing . . ."

Third of a series on various specialties

How to Equip the Psychiatrist's Office

The cost need not be excessive. But the important requirement of a relaxed atmosphere and decor should be your guide in choosing the location and planning the layout of the psychiatry office.

Before considering the equipment needed in the practice of psychiatry, the resident would do well to keep in mind a few facts which find general agreement among the practicing psychiatrists queried in connection with this article.

First, the office should be as unlike a business office as it's possible to make it. Filing cabinets, typewriters, metal office furniture, even a telephone or inter-office communication box should not be in evidence either in the waiting room or in the consultation room.

And just as the office should avoid this stripped-for-action appearance, it would be equally unsuitable to reflect a clinical atmosphere where the patient might get the impression from the display of professional equipment that he is in for a tense session of scientific scrutiny by a brain engineer.

Such things as a tape recorder, dictating machine, medical school, intern and residency certificates, and most importantly, shock equipment should not be displayed in waiting or consultation rooms. The treatment room is the proper place for the latter equipment.

Stuffy

The foregoing does not mean that the psychiatrist's waiting room or consultation room should take on the stuffy decor of an 18th Century drawing room or

an Elizabethan lounge. Ornate furnishings and ultra-plush appointments are overpowering to the average patient; just as the too-modern, completely functional design used in some offices creates a harsh and uncompromising aspect to the disturbed individual.

Comfort

Thus, in psychiatry, the important consideration in the selection of furnishings for the office should be to promote the comfort and relaxation of the patient through somewhat homelike surroundings.

How to do this? According to psychiatrists responding in the RESIDENT PHYSICIAN survey, keep in mind the atmosphere of the average living room. That is, furniture can be modern, provincial, colonial or practically any period style (if you can afford it) just so long as the general arrangement is in good taste—not jarring to the senses with odd color combinations or offbeat decorative effects.

"Neither too gay nor too gray," comments one psychiatrist.

"The true measure of tasteful selection and arrangement of furniture," advises another, "is when no single piece stands out from all the rest—everything should get along with everything else. That way, it's restful."

Rapport

Another psychiatrist puts it this way: "When you get rich and earn a high reputation in the process, then you can put on a show. By that time, some of your patients will be coming to you expecting to be impressed with your office. You can't afford to disappoint them. But

---

What equipment is needed by the psychiatrist who is completing his residency and preparing to open an office?

RESIDENT PHYSICIAN recently put this question before a number of practicing psychiatrists. Cautioned to keep in mind that cost was an important factor for the man starting out, many respondents described some of the mistakes they had made.

Based on their experience, this article is presented as a general guide for those residents who will soon be equipping offices for the practice of psychiatry.

---

starting out, you can't afford to offend or irritate them either because any continuing source of irritation, however minor, plays hell with the rapport."

Privacy

A second factor of importance concerns the location of the office itself. It should be kept in mind that the patient very often desires that his comings and goings be conducted in privacy, away from the public eye. This sensitive consideration cannot be ignored by the beginning psychiatrist, according to the panel of responding psychiatrists.

In this same connection, it is wise to have an arrangement whereby the patient may leave the office without going through the waiting room. Big city or small community, the need for these special considerations is the same.

Waiting room

The psychiatrist's waiting room need not be large. The average waiting room, according to our survey, allowed for four occupants. Again, the decor of the room should be similar to a living room in a small home. Here's where the doctor's wife can help a lot.

Most psychiatrists suggested draw-drapes and carpeting. These promote a quiet atmosphere.

Furniture needn't be costly to be attractive. With a little shopping, suitable chairs can be purchased from $60 to $150 each. The average waiting room contained two or three chairs and a sofa. The latter can be bought new for from $200 to $350.

Carpeting

All agreed that carpeting (not linoleum, tiles, etc.) was necessary . . . if not throughout the office, at least in the waiting room and consultation room. Carpeting certainly adds dignity to any room. This, plus the quieting effect, makes carpeting well worth its greater expense as compared to other types of floor covering.

Carpet cost, of course, depends pretty much on the size of the room and the quality of the carpet. A neutral shade (easier to keep clean) of good quality wool or blended fiber would run from $8 to $13 a square yard or about $125 for a 9 x 12 room covered wall to wall. Since the average waiting room of the psychiatrists surveyed is larger than this, the average carpet cost, plus under-pad, ran to $220 among those polled.

Drapes can be expensive or

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*Toleghany, P., and Heltai, A.: Am. J. Obst. & Gynec., in press.

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†TRADEMARK

inexpensive, depending on the material, labor and number of windows. An easy rule is an average of $60 per window, installed.

Tables, lamps

Two or three small tables are important since they serve the triple function of providing a base for table lamps, a resting place for magazines, and a location for ash trays. Incidentally, never mind about the cute little ash trays suitable for a woman's bridge party. Get the man-sized jobs that'll keep cigarettes from ruining your brand new tables and carpet. Tables need not be expensive. Well-designed wooden tables can be purchased from $25-$45 each.

Table lamps add warmth to the room and can be purchased for under $40 each. Most psychiatrists expressed a preference for the table lamp over wall fixtures or floor lamps. More intimate, and uncluttered floor space were two reasons.

Consultation room

The consultation room of the psychiatrist is the most important room in his office. Here is where the bulk of the practice time is spent. It should be dignified, yet relaxing. As mentioned, carpeting is strongly suggested here as in the waiting room.

A desk, of course, is needed. The price of the desk will depend upon the style, size, and the material. In general, the average price paid for a desk, according to our survey, was $150. But, this figure varied from $50 all the way to $500. One point: the desk should be large enough, contain enough drawer space for many items the psychiatrist will want at his fingertips.

Even more important perhaps, than a desk, are the chairs for patients and for the physician. Your chair should be picked primarily for your comfort. It will be your best friend and will be near you for many years. Try before you buy. Good chairs can be expensive. According to psychiatrists, the chair they thought best, in some cases, cost as much as $250.

In choosing a desk lamp, care should be given that the light is reflected downward, not into the patient's eyes. A good desk lamp can cost anywhere from $25 to $50.

A bookcase may be a good idea in the consultation room. A bookcase is colorful, adds to the patient's confidence in the doctor. Bookcases can be purchased as a unit. The price quoted may

be $75 or $100. Bookcases can also be custom built to fit odd-sized wall areas.

Couch

The couch, of course, is an important piece of furniture in the psychiatrist's consultation room. There are many types seen in various offices, but in general they are all basically a comfortable couch with a headrest arrangement, either built in, or a pillow type arrangement. The material is usually leather or plastic; this is not only attractive but also easily maintained. The cost of such a couch is from a minimum of $150 on up, depending on material and design.

Recording device

Many psychiatrists surveyed advised some sort of recording device in their consultation room, either for keeping records or for therapy. These machines are not expensive; a suitable one will cost anywhere from $100 to $200. Tape was considered superior to wire by all responding psychiatrists.

Examining room

Many psychiatrists have an examining room or treatment room. This room serves two purposes. The first is that many psychiatrists combine a psychiatry practice with neurology and require a table for examinations. Others prefer a second room for electroshock therapy, permitting the patient to remain for a period after the "shock" without tying up the consultation room. A second room is not imperative, however, because many psychiatrists dispense shock treatment on the couch in the consultation room.

The examining room requires a basic table. A good examining table can be purchased new for from $250 to $800. The difference in price depends upon the type of materials, decorations, and extra features provided. Some psychiatrists, at the beginning, purchase an examining table secondhand.

A secondhand examining table in good condition usually can be purchased for under $100 and an adequate refinishing can be done for $25 to $30.

A treatment cabinet and a treatment stand may not be necessary right away. Perhaps money could be saved by using wall shelves or built in cabinets to serve the same purpose.

Examining lamps vary from as little as $15 to as much as $260 and more; the difference depending upon the source of light, type of illumination, and size.

now...for edema and hypertension

Esidrix
(hydrochlorothiazide CIBA)

milligram-for-milligram
the most effective oral
diuretic-antihypertensive

2/2067MP-1

Improved diuretic-antihypertensive; high degree of activity, low toxicity

Esidrix T.M.

(hydrochlorothiazide CIBA)

Greater activity: Milligram-for-milligram, Esidrix is the most effective oral diuretic known. With a therapeutic efficacy comparable to parenterally administered mercurials, Esidrix is from 10 to 15 times more potent than chlorothiazide and therefore provides the same therapeutic benefits with but 1/10 to 1/15 the dosage. Animal studies indicate that Esidrix is longer acting than chlorothiazide, providing a smoother response.

Low toxicity: According to animal studies, Esidrix is markedly less toxic than chlorothiazide and is therefore an exceptionally safe diuretic-antihypertensive.

Patients unresponsive to chlorothiazide and mercurials in many cases respond readily to Esidrix.

Use in hypertension: Esidrix may be used alone or in combination with other antihypertensive drugs to bring about effective lowering of blood pressure. The drug potentiates the action of all other antihypertensive agents.

Less dietary salt restriction: In many cases, Esidrix permits some moderation in severe sodium restriction and therefore makes meals more palatable.

Dosage: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets administered 2 or 3 times a day.

Supplied: TABLETS, 25 mg. (pink, scored); bottles of 100.
TABLETS, 50 mg. (yellow, scored); bottles of 100.

C I B A
2/9569HK-2 SUMMIT, N. J

Some psychiatrists prefer giving "shock" on a bed rather than on an examining table or a couch. Such a bed can be bought for under $75.

The electric shock machine should be purchased new, most psychiatrists advised, since it is an electrical apparatus.

The cost varies with the type of machine, but 70% of the men surveyed spent less than $250.

A small sterilizer and a few syringes are needed for the office. The total cost of the sterilizer, syringes and drugs needed will probably be under $75.

Expense

The editors have attempted to give psychiatrist readers an overall view of the cost of outfitting the beginning office in psychiatry. Many items are omitted. Many offices can be (and are) much more elaborately equipped. Also, special consideration was given to price.

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure was to be complete, including any items such as typewriters, nurse's desk, nurse's chair, filing cabinet, etc., some of which you may not need.

Some 20% of our group outfitted their offices for under $1500. More than half spent $2000 to $3000 on their initial office equipment. Thirty percent stated that their offices cost more than $3000.

Remember, prices have increased since the psychiatrists surveyed entered practice. Therefore, a rough estimate would indicate that the average office for the practice of psychiatry can be equipped for approximately $2500-$2600.

How to Speak Italian:

Key Words for the Clinic

You don't have to be a language expert to handle a medical history and examination of a non-English-speaking patient. Here are medical words and phrases to help you break the language barrier.

IN many areas of the U.S., the number of foreign-born still comprises a large segment of the total population. In hospitals and medical centers located in these areas, physicians are frequently called upon to examine and treat patients who speak little or no English. To ease the anxiety of the patient and to help the physician conduct an efficient, accurate examination and history-taking, RESIDENT PHYSICIAN has compiled translations of commonly used medical directions, questions and answers. If a word doesn't seem to be understood by the patient, repeat it a few times slowly, varying the pronunciation slightly until the patient indicates his understanding. Remember, the very fact that you are trying to speak to him in his native language will cause your patient to be more relaxed and responsive. Grateful for your efforts, he will do everything he can to comprehend and convey accurate, precise information.

now, for the first time, **liquid** meprobamate

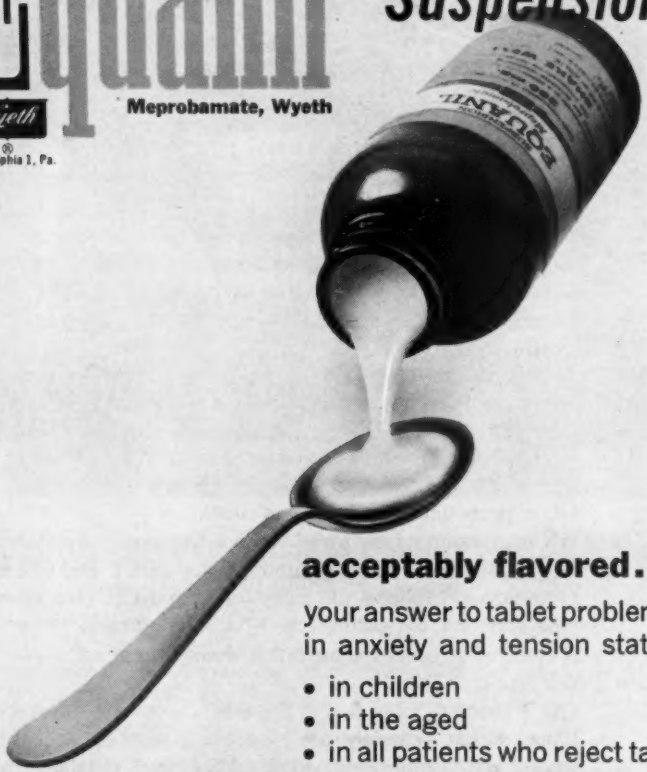
Equanil®

Suspension

Wyeth

Meprobamate, Wyeth

Philadelphia 1, Pa.



acceptably flavored...

your answer to tablet problems in anxiety and tension states

- in children
- in the aged
- in all patients who reject tablet medication

SUPPLIED: Suspension, 200 mg. per 5-cc. teaspoonful, bottles of 4 fluidounces. Also available: Tablets, 400 mg., scored; bottles of 50; 200 mg., scored, vials of 50. WYSEALS® EQUANIL, tablets, 400 mg., vials of 50.

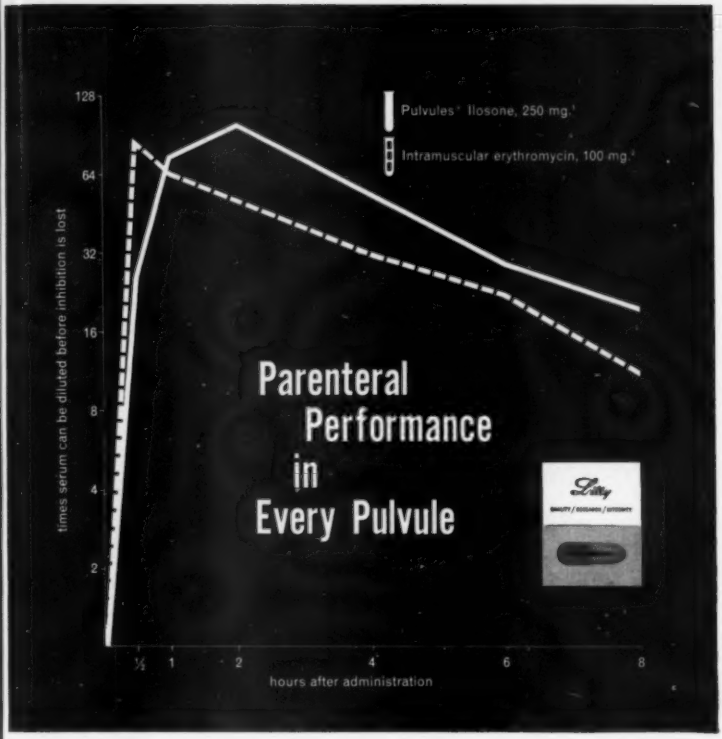
RELIEVES TENSION—MENTAL AND MUSCULAR

PHYSICIANS' COUNCIL · INFORMATION ON CHILD HEALTH

Conforms to Code for Advertising

Basic rules of pronunciation

1. The sound of vowels is constant with the exception of e which has two sound values.
   a—*ah*
   e—*eh*
   e—*ay* (generally used in word endings)
   i—*ee*
   o—*oh*
   u—*oo*
2. The sound of consonants varies depending upon the consonant vowel combination.
   C before a, o and u, is pronounced as the C in *cat*.
   C before e and i takes the sound of CH in *chair*.
   G follows the above rules also; before a, o and u, G is "hard" pronounced like G in *go*: before e and i, G becomes G as in *gentle*.
   However, both C and G are pronounced "hard" before e and i when the letter H appears between the consonant and vowel. Thus, CH in ocCHio is pronounced as the English *k*, and Pinocchio becomes *pee-noh-kee-oh*.
   GU as always pronounced *goo* as in *goose*.
   GL is pronounced as *l*, the *g* is silent.
   GN is pronounced the same as the *ni* in *onion* and *senior*.
   SC and SCH have the ess sound coupled with C and CH and the pronunciation follows the rules for C and CH (see above).
   One variation; SC before e or i becomes *sh* as in *sheep*.
   R is trilled at tip of tongue rather than gutteral roll.
   Z is like *tz* in *tzar*.
   QU is pronounced as it is in English.
3. Italian words, generally, are pronounced with the accent on the second last syllable. In words of only two syllables, the first syllable is usually emphasized.
4. Plurals do not end in s as in English, French and Spanish. Masculine gender plural nouns usually end in i, while feminine plural nouns generally end with e.



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Parenteral potency—The graph above shows that Ilosone provides antibacterial serum levels comparable to those obtained with intramuscular therapy.

Parenteral certainty—In more than a thousand determinations, in hundreds of patients studied, Ilosone has never failed to provide significant antibacterial levels in the serum.

The usual dosage for adults and children over fifty pounds is 250 mg. every six hours, but doses of 500 mg. or more may be administered safely every six hours in more severe infections. For optimum effect, administer on an empty stomach. Supplied in Pulvules of 250 mg. (For children under fifty pounds, a 125-mg. Pulvule is also available.)

1. Antibiotic Med. & Clin. Therapy, *5:* 609, 1958.
2. Data from Antibiotics Annual, p. 269, 1954-1955.

Ilosone™ (propionyl erythromycin ester, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

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new

research shows
LINOLEIC ACID ESSENTIAL TO INFANT NUTRITION

Hansen's and co-workers' research [1,2,3] on linoleic acid indicates three important new facts:

I. Linoleic acid is essential in infant nutrition.

II. Linoleic acid is essential for maintaining skin integrity.

III. Optimum caloric efficiency is attained when at least 4 to 5% of the caloric intake is linoleic acid —the amount present in normal human milk.

Varamel—because it replaces butterfat with suitable vegetable oils—provides enough linoleic acid for both skin integrity and optimum caloric efficiency.

Varamel provides 6% of the calories as linoleic acid; cows' milk and ordinary evaporated milk formulas provide about 1%.

1. Wiese, Hilda F., et al.: J. Nutrition 66: 345, 1958
2. Adam, Dorie J. D., et al.: Ibid.: 555
3. Hansen, A. E., et al.: Ibid.: 565


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THE BAKER LABORATORIES, INC.
Makers of Baker's Modified Milk • Cleveland 3, Ohio
OPTIMUM
NUTRITION

Anatomical terms

head—testa or capo
eye(s)—occhio (occhi)
ear(s)—orecchio (orecchi)
nose—naso
mouth—bocca
teeth—denti
tongue—lingua
throat—gola
finger—dito
leg(s)—gamba (gambe)
feet—piedi
stomach—stomaco
bladder—vescica
neck—collo
chest—petto *or* torace
breast—seno
heart—cuore
lungs—polmoni
shoulders—spalle
back—schiena
arm(s)—braccio (braccia)
hands—mani
rectum—retto
buttock—natica
womb—utero

Courtesy phrases

Note: Normal courtesy requires the frequent use of the titles *Signore* (Sir), *Signora* (Madam) and *Signorina* (Miss). For the sake of brevity these titles are used only in the first three phrases below.

Good morning, Sir	Buon giorno, signore *boo ohn jeeohrnoh seenyohray*
Good afternoon, Madam	Buona sera, signora *boo ohna sayrah seenyohrah*
Good night, Miss	Buona notte, signorina *boo ohna nohtay, seenyohree-nah*
Please	Favorisca *or* per piacere

(In giving directions to patients, *favorisca* or *per piacere* should be used to begin each statement.)

Please sit down	Favorisca s'accomodi
How are you?	Come sta lei
Very well, thanks	Benissimo, grazie
Do you understand	Comprendi, (capisci)
I (do not) understand	(non) capisco
Excuse me	Scusi
Pardon me	Perdoni

BUTIBEL®

antispasmodic-sedative

puts the "jumpy," nervous g. i. tract back on schedule—with its regulative antispasmodic-sedative action.

BUTIBEL brings relief through the non-cumulative sedation of 15 mg. BUTISOL Sodium® butabarbital sodium combined with the antispasmodic action of natural extract of belladonna 15 mg. (per tablet or 5 cc.)—each ingredient having approximately the same duration of action.

BUTIBEL Tablets • Elixir • Prestabs® Butibel R-A
(Repeat Action Tablets)

McNEIL

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Philadelphia 32, Pa.

Very good	Buonissimo
Today	Oggi
Tomorrow	Domani
Yesterday	Ieri

General questions

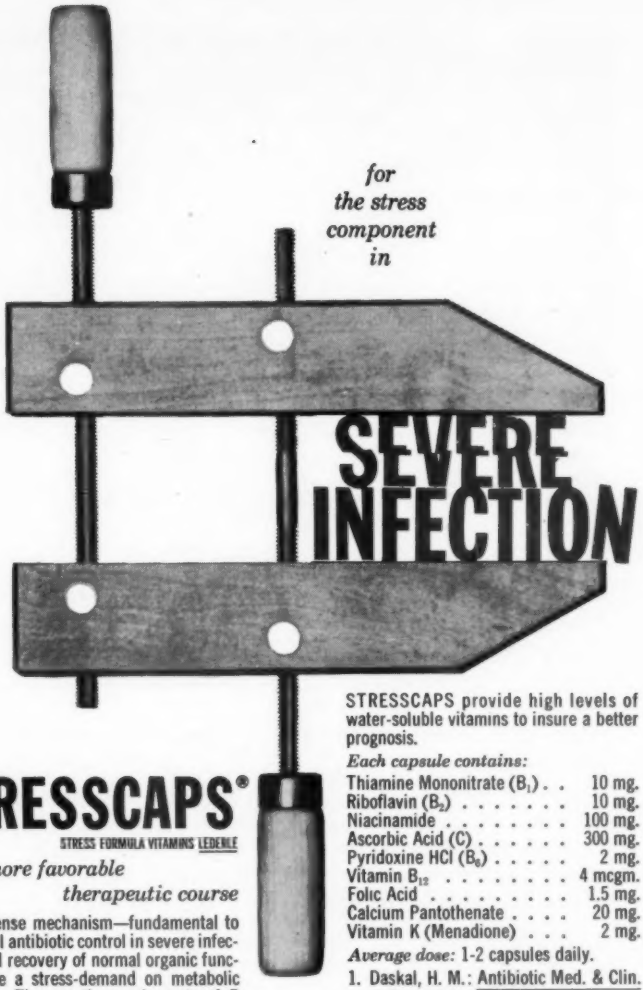
do you feel sick	vi sentite male
do you have pain	vi fa male
—much pain	—molto male
—mild pain	—male poco
where	dove
here	qui
when	quando
how many years	da quanti anni
how many days	da quanti giorni
how many hours	da quante ore
how many times	quante volte
how old are you	quanti anni avete
where were you born	dove siete nato

Directions to patients

do as I do	fate come faccio io
relax	calmatevi
relax more	calmatevi di piu
open your mouth	aprite la bocca
open your eyes	aprite gli occhi
breathe deeply	respirate profondamente
breathe through your mouth	respirate per la bocca
hold your breath	trattenete il respiro
push	spingete
cough	tossite
please don't move	per piacere, non si muova

Diseases

measles	morbillo
scarlet fever	scarlattina
chicken pox	varicella
small pox	vaiuolo



STRESSCAPS®

STRESS FORMULA VITAMINS LEDERLE

for a more favorable therapeutic course

Host defense mechanism—fundamental to successful antibiotic control in severe infection—and recovery of normal organic function place a stress-demand on metabolic processes. Therapeutic supplements of B and C vitamins, as the basis of enzyme activity, protein-carbohydrate utilization, endocrine response and antibody formation,[1] are often required.[1,2]

STRESSCAPS provide high levels of water-soluble vitamins to insure a better prognosis.

Each capsule contains:

Thiamine Mononitrate (B_1)	10 mg.
Riboflavin (B_2)	10 mg.
Niacinamide	100 mg.
Ascorbic Acid (C)	300 mg.
Pyridoxine HCl (B_6)	2 mg.
Vitamin B_{12}	4 mcgm.
Folic Acid	1.5 mg.
Calcium Pantothenate	20 mg.
Vitamin K (Menadione)	2 mg.

Average dose: 1-2 capsules daily.

1. Daskal, H. M.: Antibiotic Med. & Clin. Ther. 2:33 (June) 1956.
2. Pollack, H. and Halpern, S. L.: Therapeutic Nutrition, National Research Council, Washington, D. C., 1952.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

pneumonia	polmonite
typhoid fever	febbre tifoidea *or* tifo
enteritis	enterite
U.R.I.	raffreddore

Systemic inquiry

Head	
trauma	trauma
unconscious	incosciente
did you faint	siete svenuto
are you dizzy	vi sentite il capogiro
headache	mal di capo
Eyes	
sight	vista
clear vision	buona vista
near	vicino
far	lontano
Ears	
he is deaf	egli e'sordo
noise in the ears	rumore alle orecchie
Nose	
coryza (head cold)	coriza (raffreddore di testa)
did you have a nosebleed	vi ha sanguinato il naso
Throat	
do you often have a sore throat	vi sentite il mal di gola spesso
Cardio-respiratory	
do you tire easily	vi stancate facilmente
are you short of breath	vi sentite mancare il respiro
does your heart beat fast	vi batte il cuore presto
do your feet swell	vi si gonfiano i piedi
do you have pain in the chest	avete dolori al petto
—sharp pain	—dolore acuto
—dull pain	—dolore vago
—when you breathe	—quando respirate
do you cough	tossite
do you spit	sputate
sputum	sputo
bloody sputum	sputo insanguinato

"More loads per day in less time!"

The 999 double shell gives you standby steam reserve for instant use

There's hardly any waiting for steam build-up with Castle's new super-fast 999 Autoclave.

Turn it on in the morning and it will automatically maintain a full reserve supply of steam in the jacket for day-long readiness. No waiting . . . no watching.

Then, whenever you want to sterilize, one turn of the single dial control handle and temperature starts building instantly in the chamber. You get more loads per day in less time.

But speed isn't all the 999 has to offer. It's convenient too with a full 9 x 16-inch chamber, bulk supply rack, two oversize trays; one 8½ x 15". Everything goes in . . . with room to spare. Exclusive features include a visible water-level gauge, and reversible door swing for left or right opening.

The most beautiful autoclave yet, with all valves and mechanical parts enclosed in a handsome, enameled cabinet . . . with a choice of Coral, Jade Green, or Silvertone decorator shades.

Ask your dealer for a demonstration, or write for new 999 full-color folder.

Castle LIGHTS & STERILIZERS

WILMOT CASTLE COMPANY • 17301 East Henrietta Rd., Rochester, N.Y.

have you lost weight	siete diminuito di peso
pound	libbra
does someone in your family have a cough	C'e'qualcuno nella vostra famiglia che tossisce

Gastrointestinal

do you have a good appetite	avete un buon appetito
do you have a poor appetite	avete poco appetito
are you nauseated	vi sentite nauseato
were you nauseated	vi sentivate nauseato
do you vomit	vomitate
do you have diarrhea	soffrite di diarrea
are you constipated	siete stitico
feces	feci
black	nero
white	bianco
yellow	giallo
brown	bruno
bloody	insanguinato
do you have cramps	avete dei crampi
after meals	dopo e mangiade (*or* pasto)
before meals	prima dei mangiade
did you take a laxative	avete preso un lassativo
did you take castor-oil	avete preso dell'olio di ricino

Genitourinary

urine	urina
do you get up at night to urinate	vi alzate la notte per urinare
does it burn	vi sentite bruciore
chills	brividi di freddo
fever	febbre

Obstetrics and gynecology

at what age did you begin to menstruate	a quale eta' vi sono incominciate le menstruazioni
how many days do you flow	per quanti giorni avete il flusso

"Anticholinergic drugs alone are inadequate in the management of peptic ulcer. . . . They should be administered only as adjuncts to conventional treatment with antacids, diet, sedation, and other therapeutic measures."[1]

1. Kirsner, J.B., et al.: M. Clin. North America *41*:499 (March) 1957.

n peptic ulcer: six aids to total management

ALUDROX SA is not only an effective anticholinergic, but also an ntacid, sedative, demulcent, anticonstipant, and pepsin-inhibitor. hus, one convenient preparation satisfies six requirements of total eptic-ulcer therapy.

An important new anticholinergic of demonstrated usefulness, *am- utonium*, is responsible for the potent antisecretory and antimotility roperties of ALUDROX SA.

NEW

SUSPENSION TABLETS

ALUDROX® SA*

Aluminum Hydroxide Gel with Magnesium Hydroxide, Ambutonium Bromide, and Butabarbital, Wyeth

edative and Anticholinergic

Wyeth

Philadelphia 1, Pa.

1 to 10	una, due, tre, quattro, cinque, sei, sette, otto, nove, dieci
do you have discharge	scarciate (avete dello scarcio) perdite
when was your last menstrual period	quando avete avuto l'ultimo periodo menstruale
are you pregnant	siete incinta
do you have pain with your period	i vostri periodi sono accompagnati da dolori
how many times have you been pregnant	quante volte sieta stata incinta
how many children have you had	quanti figli avete avuto
how much did the largest weigh at birth	quanto pesava il piu grande dei vostri bambini al momento della nascita
what was the duration of labor	quanto sono durate le doglie del parto (quanto dura)

Pediatrics

did you have trouble with the child's delivery	si sono stati disturbi durante il parto
how are the child's stools	come sono gli escrementi del bambino*
constipated	stitico**
diarrhea	diarrea
how many in one day	quante volte in un giorno
does the child eat well	il bambino mangia bene
any vomiting	c'e del vomito
does the face turn blue	il bambino* diventa paonazzo in viso
does the child seem tired	il bambino* sembra stanco
does it hurt	fa male
it won't hurt	non fa male
it will be finished in a minute	in un minuto sara tutto finito
do you want a piece of candy	vuoi una caramella
did you take the temperature	avete misurato la temperatura

what was the temperature	che temperatura avete
what a big, handsome boy	che bel ragazzo
what a beautiful little girl	che bella ragazzina
baby	bambino*
good	buono

*bambina, if female child

**stitica, if female child

MEN WHO MADE THE MEDICINE

Eli Lilly—
pharmacist,
soldier,
civic leader.

COLONEL *Lilly's* VICTORY

Eli Lilly failed in two attempts to establish himself in the pharmaceutical field. At the age of 38 he tried again—and this time he was in to stay. Today, the company he founded markets ethical products throughout the world.

One day in the summer of 1854 a boy of 16 was seeing the sights in Lafayette, Indiana, a thriving town in the central part of the state. In the town square, the sign above one of the shops caught his eye. "The Good Samaritan Drug Store," it read.

Having been reared in a religious home, young Eli Lilly knew the Biblical significance of the sign and probably thought it an appropriate one for a pharmacy. He lingered near the front door for several minutes, gazing at the walls lined with rows of curiously shaped bottles and jars, and smelling the strange aromas which wafted into the street. This experience, though seemingly trivial at the time, was to have a tremendous effect on his life.

Eli was visiting his Uncle Caleb and Aunt Hennie Lilly. His home was in Greencastle, 60 miles to the south, where he had served as a printer's devil on *Asbury Notes,* a paper published by Asbury College (now DePauw University). He had done his work well and was happy enough at it, but, like most boys, he wanted to see something of the world before settling down in a career.

So this summer his parents had let him visit Lafayette. He'd come by train, quite an adventure in a day when the "iron horse," though sometimes bothered by leaky boilers and balky pistons, was the latest thing in transportation.

Eli's visit turned out to be a long one. The Good Samaritan store made such an impression on him that he told his uncle he would like to get a job there. Uncle Caleb approved, for he

Page from 1882 time book reflects "family atmosphere" of business. Workers' first names were enough.

TIME BOOK for the week ending [illegible] 1882

NAMES	M.	T.	W.	T.	F.	S.	Total Time	Rate per day	Total Amount	Amount Due	Amount Paid	REMARKS
Hereth							6				15 00	
Graff							6				15 00	
Small							6				15 00	
Harwood							6	+	2 50		14 50	Extra
Devore							6				12 00	
H. Lilly							5 3/4				9 60	
Daniel							6				7 50	
Ware							6				7 00	
Mollie					5		5 1/2				5 50	Ex
Hickey							0				0 00	
Maggie							5 3/4				4 80	Discharged
Jennie							6				5 00	
Lena	0						5				4 15	
Minnie B.							6				4 50	
Eliza	10	2 1/2	0	10	10	10	4 1/4				2 85	Dick
Rose							6				4 00	
Minnie							6				4 00	
Emmiel							6				4 00	
Lizzie							6				4 00	
Dale							6				4 00	
Mary							3				2 00	Layed off
Delia							3				2 00	"
Jane							6				3 50	
Nannie							6				3 50	
Tillie							6				3 50	
Annie							3				1 75	"
Alice							2				1 20	Dick
Ella							3				1 75	Layed off
Mollie G.							3				1 75	"
Mary G							3				1 75	"
Mary A							0				0 00	"
											165 10	
								E. D. Lilly		20 00		
Romary					12 00		6	Foreman		21 00		

E. D. LILLY & CO. MANUFACTURING CHEMISTS. INDIANAPOLIS, IND. JAN 20 1882

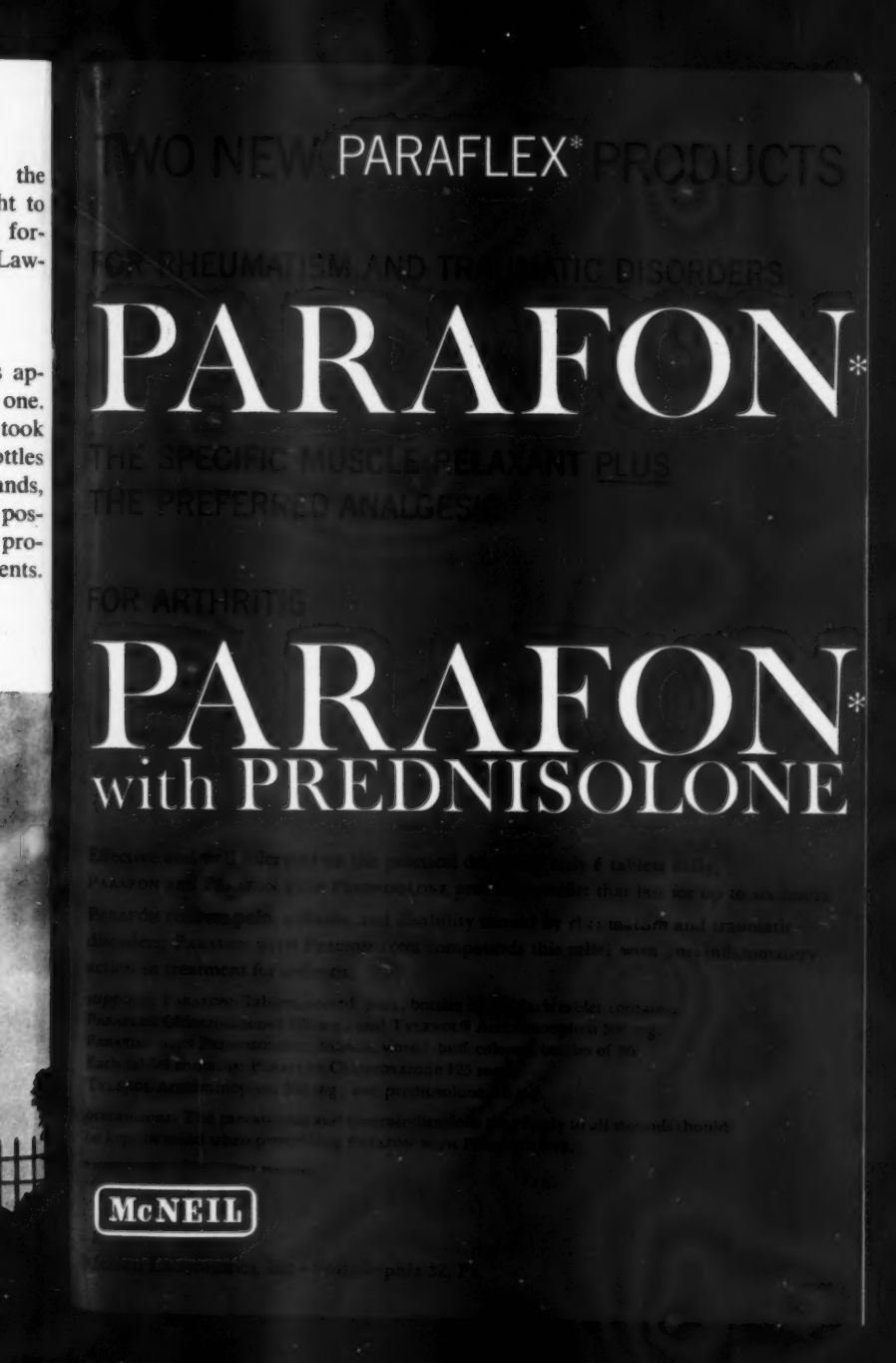
knew Mr. Henry Lawrence, the proprietor, to be a man of fine character and reputation. He called on Lawrence, and after a brief discussion the apothecary agreed to apprentice Eli for a period of five years.

Mr. Lawrence, an Englishman by birth, had himself learned the business through apprenticeship. Nowhere at the time, with the possible exception of Germany, could one get a sounder grounding in "chemistry" than in England, where, in addition to the job of mixing medicines, the apothecary also had the right to prescribe them. Lilly was fortunate to find a mentor of Lawrence's caliber.

Learning

The life of a pharmacist's apprentice was not an easy one. Eli cleaned the premises, took care of the fire, washed bottles and other containers, ran errands, kept the shelves stocked, and possibly even took care of the proprietor's horse in spare moments.

Replica of the original Lilly quarters in downtown Indianapolis. Colonel Lilly said the small laboratory was "not big enough to swing a cat in."

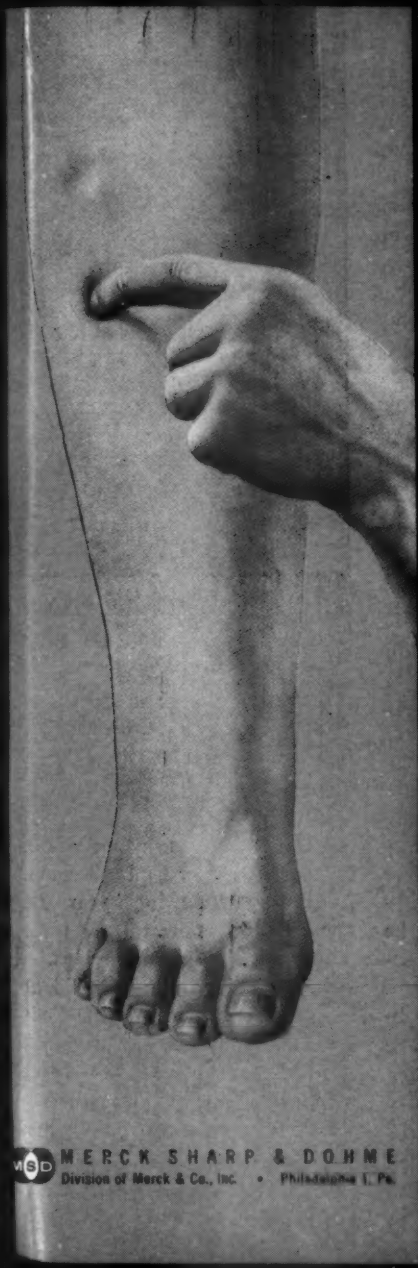

PARAFLEX*
PARAFON*
PARAFON*
with PREDNISOLONE
McNEIL

WHATEVER THE ETIOLOGY-

EDEMA OF ANY DEGREE RESPONDS TO DIURIL®

CHLOROTHIAZIDE

MSD



MERCK SHARP & DOHME
Division of Merck & Co., Inc. • Philadelphia 1, Pa.

An unparalleled record of safety and efficacy.

DIURIL has proved to be highly effective in overcoming edema associated with a wide variety of fluid retention states including: hypothyroidism, menopausal syndrome, allergy, peripheral phlebitis, arthritis, migraine headache, ascites or peripheral edema due to malignant tumor, and obesity. In the last case, Landes and Peters' achieved excellent to good results in nine obese patients in whom overweight was associated with moderate or severe fluid retention.

1. Landes, R. P. and Peters, M.: Postgrad. Med. 23: 648, June, 1958.

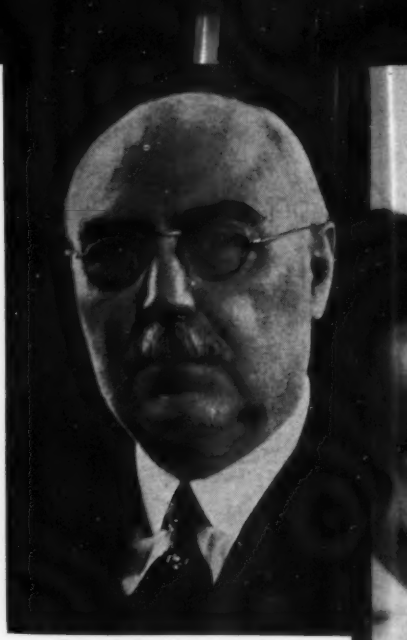
dosage: one or two 500 mg. tablets of DIURIL once or twice a day.

supplied: 250 mg. and 500 mg. scored tablets DIURIL (Chlorothiazide); bottles of 100 and 1000.

any indication for diuresis is an indication for DIURIL

Above all he was expected to keep his eyes and ears open. Evenings were supposed to be devoted, with diligent application by lamplight, to such books on the subject of pharmacy as were available.

After a year or so young Lilly was permitted to mix drugs. Between duties, he found time to join the local militia company. This labor was not onerous. Although the militia had advanced somewhat beyond the stage of drilling with cornstalks, its activities were largely gastronomic, social and political.



At 14, Josiah Kirby Lilly joined dad in business; he headed firm 22 years later.

Precision

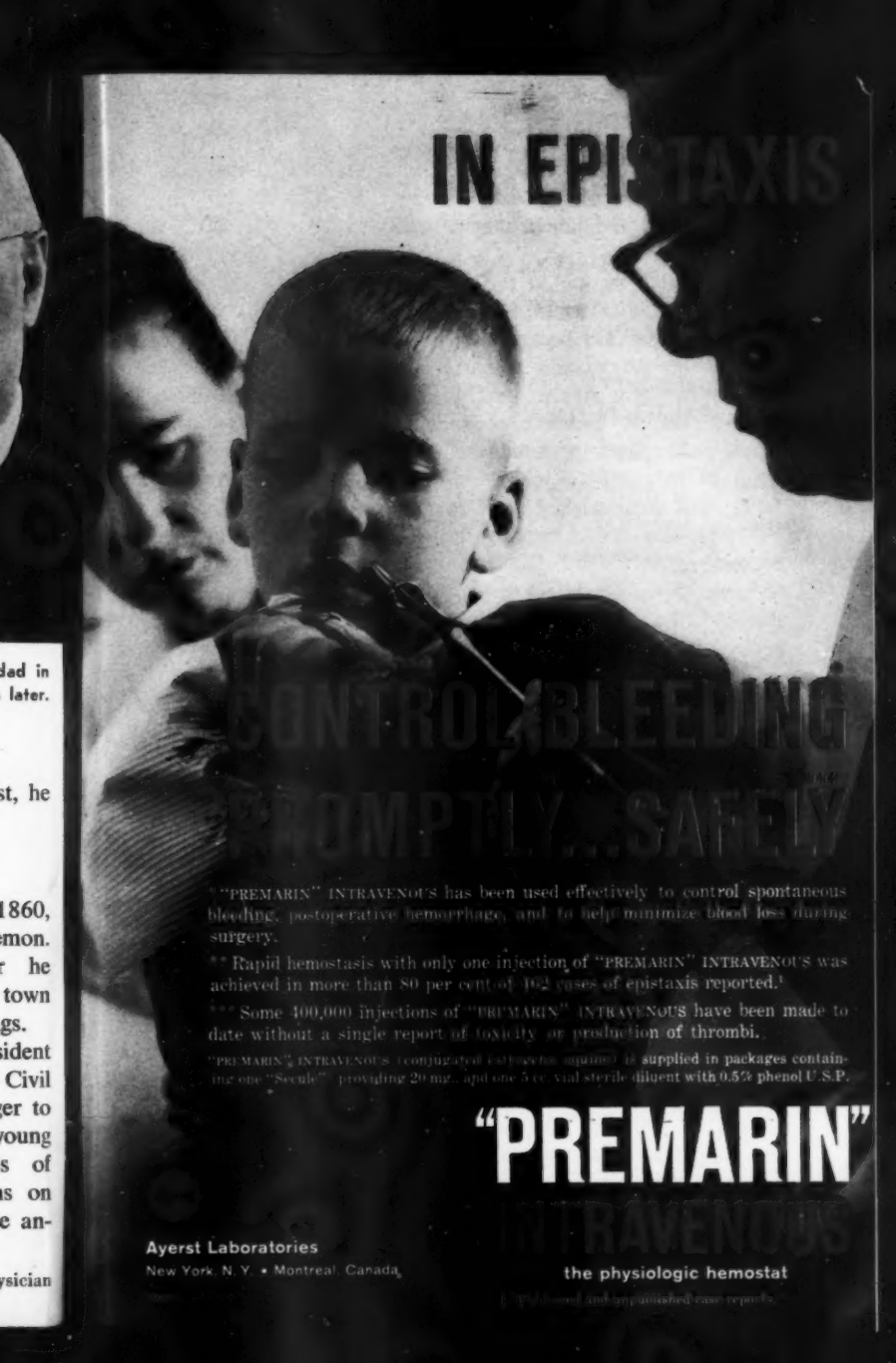
It may be assumed that during his Lafayette days young Lilly learned that the drug business, international in connections even then, was dependent upon the entire world not only for materials, but also for ideas. Certainly under the rigid regimen outlined by his master, he learned habits of industry and the precision without which a pharmacist would be of more danger than use to society.

For his work, Eli Lilly probably received the customary dollar or two per week "and keep." At the end of five years he was given a certificate of proficiency. After working a few months for another Lafayette pharmacist, he returned to Greencastle.

Civil War

Later that same year, 1860, he married Miss Emily Lemon. Early the following year he opened a drugstore on the town square with his small savings.

In April, 1861, came President Lincoln's call to arms in the Civil War. Eli Lilly was not eager to leave his new business and young wife; but, like thousands of others who had convictions on the basic issues involved, he an-



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[1] Published and unpublished case reports.

swered the call. He locked the door of his drugstore, bade his wife good-by, and joined the infantry.

After brief service in the infantry, Eli Lilly was transferred to the artillery and became captain of the Eighteenth Indiana Battery of Light Artillery. This battery, under General Rosecrans, participated in the engagement at Hoover's Gap in June, 1863, and distinguished itself in heavy fighting at Chickamauga in September.

Later, when Captain Lilly returned to Indiana, he helped organize the Ninth Indiana Cavalry, in which he became major and then colonel. He received an honorable discharge in 1865.

At the end of the war, Colonel Lilly remained in the South. He sent for his wife and small son and located on a plantation near Port Gibson, Mississippi. The cotton-planting venture proved disastrous. Drought ruined the crop, and Colonel Lilly's partner in the venture made off with the funds. But even these misfortunes must have seemed minor to Lilly when his wife Emily became ill with malaria and died.

Late in 1866, he abandoned the plantation and returned to Indiana with his son, Josiah Kirby, who was also stricken with malaria. Three years later, in 1869, Colonel Lilly was married to Miss Maria C. Sloane.

Failures

In Indianapolis he got a job in the wholesale drugstore of H. Dailey and Company, where he remained for about three years. Eager, however, to get into a business of his own, in 1869 he entered into a partnership with J. W. Binford, of Crawfordsville, and opened a drugstore. The site chosen was Paris, Illinois; the name, the Red-Front Drug Store.

In 1873 Colonel Lilly returned to Indianapolis with the idea of manufacturing drugs. In partnership with Dr. J. F. Johnston, he opened a small laboratory. A record of the new business stated that "Dr. Johnston, a dentist, furnished the capital and Eli Lilly furnished the knowledge and experience."

The partnership proved unsatisfactory. When the firm of Johnston and Lilly dissolved in 1876, Eli Lilly took as his share some equipment, cash, and several gallons of fluid extracts.

He next approached Augustus Kiefer, a wholesaler of drugs, and asked for a position with his firm. But Kiefer reminded him of his past experience and training in the compounding of drugs

...because it tastes so much richer than ordinary nonfat milk

Specify "self-enriched" Carnation Instant to help patients "stay with" low-fat diet

25% more protein, too – and it's so easy!

The physician simply specifies one extra tablespoon of crystal-form Carnation Instant per glass (or ⅓ cup extra Magic Crystals per quart) over package directions.

This provides a 25% increase in *nonfat* milk solids with no increase in liquid bulk. Each quart provides 60% of the daily protein requirement* of men – an important factor when other major protein sources are severely restricted, as in low-fat diet.

Most people *enjoy* "self-enriched" Carnation Instant Nonfat Dry Milk because the flavor is naturally fresh and far richer than ordinary nonfat milk.

Thus, Carnation Instant, "self-enriched," helps patients stay with low-fat diet two ways: because it is more delicious for drinking; because it provides extra protein to help maintain stamina and well-being.

**National Research Council*

Physicans turn to Tessalon® to control cough

Single agent with multiple actions broadens cough therapy

A single therapeutic agent developed by CIBA research now does all that has been attempted with combination cough remedies. Extensive clinical trials, involving more than 3,000 patients with acute or chronic cough, have shown that TESSALON *has at least six advantages* that result in better total management of the patient with cough:

1. TESSALON acts peripherally, to control cough in the chest.
2. TESSALON acts centrally, to control cough at the level of the "cough center" in the medulla.
3. TESSALON is reported to thin sputum.[1]
4. TESSALON increases vital capacity and ventilation.
5. TESSALON improves exercise tolerance.
6. TESSALON relieves dyspnea.

Fewer coughs per minute

Shane and co-workers,[2] using the method of Bickerman and Barach,[3] induced measurable cough in 20 volunteers, using a 15 per cent citric acid aerosol as the cough-producing agent. The antitussive efficacy of TESSALON (100 mg.) was estimated to be 2½ times that of codeine (½ grain) in this test.

Cough suppressing activity of TESSALON[3]

	Average Number of Coughs*
No therapy	8.3
Codeine	4.4
TESSALON	1.7

*Based on 5-minute interval immediately following inhalation of citric acid to induce cough. Each patient was tested on three separate occasions.

Controls cough in the chest

It has been shown that the increased sensitivity of the sensory receptors in the lung during inspiration is an important part of the cough mechanism. TESSALON has a selective inhibiting effect on these dilation or "stretch" receptors[4] that helps to control cough where cough begins—at points of irritation in the chest.

Controls cough at the cough center in the medulla

Spinal reflex arcs were studied for the inhibitory effect of TESSALON on the transfer of afferent cough impulses to the efferent branch of the cough reflex.[5] The administration of TESSALON inhibited reflex transmission, when the afferent nerve was stimulated electrically. With this "damping" effect on the cough center in the medulla, TESSALON controls cough centrally, as well as peripherally.

Thins sputum

TESSALON controls cough frequency without interfering with productivity or expectoration. In fact, sputum is usually thinner, easier to raise.[1]

Effect of TESSALON on sputum[1]

Amount		Consistency	
Less	32 patients	Heavier	3 patients
More	2* patients	Lighter	27 patients
Same	16 patients	Same	20 patients

*These patients noted more but lighter sputum.

Increases vital capacity

Respiration usually increases both in depth and volume during TESSALON treatment.[6] In one study,[7] patients with chronic respiratory disease, with and without bronchospasm, showed a mean increase of 19.7 per cent in vital capacity after a 2-week course of TESSALON.

Improves exercise tolerance

By inhibiting stretch receptor activity, and by increasing air intake, TESSALON enables patients to tolerate exercise or work better, eliminates many paroxysms of coughing.

Relieves dyspnea

Farber and Wilson[8] note that one of the important contributions of TESSALON to cough therapy is "...its action as a reliever of dyspnea in some patients." Shortness of breath, wheezing, weakness, "blackouts" are not likely to trouble the patient treated with TESSALON.

Fast, prolonged action

The cough suppressant effect of TESSALON starts rapidly—usually within 15 to 20 minutes. The duration of effect is prolonged—usually from 3 to 8 hours.

Indications

TESSALON is indicated in acute and chronic cough.

ACUTE: Common cold, Bronchitis, Pneumonia, Upper respiratory infection, Pleurisy, Spontaneous pneumothorax, Bronchial irritation provoked by gases and foreign bodies. CHRONIC: Pulmonary emphysema, bronchitis (emphysematous, asthmatic), bronchial asthma, Tuberculosis, other chronic pulmonary diseases, Pulmonary or mediastinal tumors

PROCEDURES: Bronchoscopy and bronchography, Thoracentesis, Thoracic surgery

Dosage

ADULTS: Average dosage is one Perle (100 mg.) t.i.d. If necessary, or where cough is refractory, up to 6 Perles (600 mg.) daily may be given.

CHILDREN UNDER 10: One Pediatric Perle (50 mg.) t.i.d. is the usual dosage.

The Perles should be swallowed without chewing, and, if necessary, with a liquid. Release of TESSALON from the Perle in the mouth produces a temporary local anesthesia of the oral mucosa.

Side Effects

TESSALON is well tolerated. Only occasionally have side effects been reported. Skin rash, nasal congestion and a vague "chilly" sensation have been mentioned. In rare instances, gastrointestinal upset, constipation or sedation have been observed. No adverse effects on respiration, kidney or liver function tests, blood count or urinalysis were reported.

Supplied

Perle form (liquid-filled gelatin spheres) provides speed of liquid medication—convenience and dosage accuracy of capsule medication. In two strengths: 100-mg. Perles (yellow), for adult use; 50-mg. Perles (red), for children under 10.

Samples available on request.

References

1. Simon, S. W.: Ann. Allergy 15:521 (Sept.-Oct.) 1957. 2. Shane, S. J., Krzyski, T. R., and Copp, S. E.: Canad. M.A.J. 77:660 (Sept. 15) 1957. 3. Bickerman, H. A., and Barach, A. L.: Am. J. M. Sc. 228:156 (Aug.) 1954. 4. Bein, H. J., and Bucher, K.: Helvet physiol. et pharmacol. acta 15:55 (March) 1957. 5. Meier, R., and Bein, H. J.: Personal communication. 6. Michelson, A. L., and Schiller, I. W.: J. Allergy 28:514 (Nov.) 1957. 7. Bickerman, H. A.: To be published. 8. Farber, S. M., and Wilson, R. H. L.: To be published.

TESSALON® (benzonatate CIBA) a/5411M

Controls cough where cough begins—in the chest.

Controls cough at the cough reflex center—in the medulla.

Thins sputum.

Increases vital capacity and ventilation.

Improves exercise tolerance.

Relieves dyspnea.

CIBA

and encouraged him to start a small business of his own. Together they talked it over with the half-dozen other wholesalers in Indianapolis, all of whom promised to support Lilly in distributing his products if he would make a line of pills, fluid extracts, elixirs, and cordials.

Thus in 1876, at the rather mature age of 38, Eli Lilly, having failed to achieve success in two enterprises, was still seeking to establish himself in the business of his choice. He decided to try once more.

Another start

On the balmy spring morning of May 10, 1876, Eli Lilly walked briskly to a downtown alley, known by courtesy as Pearl Street. Here he turned a big key in the double doors of a small building and with fresh hope began a new business.

Above the door of the shop, probably the smallest pharmaceutical plant in the United States at the time, hung a sign which read simply, "Eli Lilly, Chemist." This was the humble beginning of a business which was

THE LILLY LINE

The earliest traceable ancestors of the Lilly family lived in Sweden almost 700 years ago. In 1291, in the province of Södermanland, near Stockholm, lived one Andreas. From Suno Anderson (son of Andreas), who lived in Ofver-Sela socken (parish), Södermanland Province, stemmed the line which was to adopt the name "Lillja." At Ulricehamn in 1470 was born the first Eli Lillja (eighth generation) of whom there is any record.

Following a Scandinavian practice of some centuries standing, Eli Henri Lillja (ninth generation) moved to France in the early 1500s. It was he who first adopted the spelling "Lillie," which in time became "Lilly."

About the time of the American Revolution, Gustavus Lilly moved to England, then in 1789 to Baltimore County, Maryland. Several miles outside Baltimore, on the Liberty Road, the Lillys operated a plantation of more than 1000 acres, raising grain, stock and some tobacco. In 1837, Gustavus Lilly, grandson of the Gustavus who came to America, married Esther Elizabeth Kirby. In 1838 their first son, Eli Lilly, was born.

While Eli was still an infant, his parents, heeding the call of the West, moved to Lexington, Kentucky. The Bluegrass was beautiful country, but not all who came to it found fortune. The Lillys moved north to Greencastle, Indiana, where the father continued his occupation as carpenter and building contractor and where Eli grew up.

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to grow into one of the world's leading manufactories of pharmaceutical and biological products.

Undoubtedly, the setbacks of previous years increased Colonel Lilly's determination to make this project succeed. With capital of $1300, about half in cash and half in fluid extracts, he started to work. The story of the next 20 years, one that has often been enacted in American history, was that of a man who was willing to plan, invest, assume risks, and work; of a man who had faith in his product and in the future of his country.

The first Lilly organization was a quartet. In addition to Colonel Lilly, there were Albert Hall, who was chief compounder; Miss Caroline Kruger, "who bottled and finished the goods"; and Josiah Kirby Lilly, aged 14, who was porter, engineer, miller, mass maker, bottle washer, and errand boy. Joe, the baby who had left Port Gibson critically ill, had grown up. He had left school to help his father but later enrolled at the Philadelphia College of Pharmacy.

From the beginning it was Colonel Lilly's decision to manufacture products for use by the physician. Had financial considerations been the only ones, he might have embarked upon the manufacture of "patents" and "proprietaries," which had become big business in the United States during the preceding 75 years.

At the time Colonel Lilly made the choice to take the "ethical" path, it appeared far less remunerative. He could not foresee that the slow results of education and pure-food and drug legislation would, in the end, make it surer as well as more satisfactory.

Progress

Eli Lilly was not diagnosing and prescribing, only manufacturing, and the precedent he set has been faithfully followed to this day. The Colonel took his turn on the road as a salesman and, when he had accumulated a stack of orders, would return to the little Pearl Street plant to work in his shirt sleeves helping to make and package the medicines. The first pound of material finished at the Lilly laboratory was delivered in a basket by young Josiah Lilly to Augustus Kiefer a few blocks away.

The original building at 25 West Pearl Street was described by Colonel Lilly as "not big enough to swing a cat in." Furnishing space of only 18 by 40

Though drug-making has been revolutionized, the pans used for sugar-coating tablets in Colonel Lilly's time were much the same as those used today.

feet, it was outgrown within two years. When sales totaled $30,098.94 in 1878, it became necessary to seek larger quarters.

These were found at 36 South Meridian Street, just a few feet from the original building. As business increased, the little manufacturing establishment overflowed into an adjoining room at 38 South Meridian Street.

In 1880 when sales had grown to $65,992.12, it was decided to incorporate. What had been a personally owned and conducted business now became Eli Lilly and Company, with a capital stock of $40,000 and with Eli Lilly as president and treasurer.

Property purchased

It became apparent that the downtown buildings, with little or no room available for expansion, were unsuited to manufacturing. On April 21, 1881, property was purchased on McCarty Street and the business moved to its present location.

In the depression years of 1893 and 1894 there was much unemployment in Indianapolis.

Colonel Lilly, then president of the Commercial Club (now the Indianapolis Chamber of Commerce), headed a movement to ease the distress of the poor and unemployed.

A food market was opened, and every able-bodied man was given work on city improvements and was paid in food for his labor. The practical and successful manner in which this plan was carried out gained national recognition for Indianapolis.

Colonel Eli Lilly lived to see the business which he had founded pass safely through the difficult period of the 1890s. In his later years, despite the increasing demands of the business, he gave liberally both of his time and funds to civic affairs.

He died June 8, 1898, after an illness of about a year. At the time of his death an Indianapolis *News* editorial paid him tribute as follows:

In the death of Colonel Eli Lilly, the state and the city lost a brave and gallant soldier, a distinguished citizen, a generous, public-spirited, and benevolent man. All good causes were sure of ready sympathy when presented to him. He loved Indianapolis; and everything that helped to build it up, to improve its condition, to make life easier and better for the people, won his loyal and unwearying support. He freely gave of his means; he gave more freely still of his personal endeavor.

Growth

It has been said that any institution is but the lengthened shadow of a man. In the case of Eli Lilly and Company, that man was Colonel Eli Lilly. He was succeeded in the presidency of his company by his son, Josiah Kirby Lilly, who served from 1898 to 1932 and who died in 1948, and by his two grandsons. Eli Lilly, president from 1932 to 1948, is now chairman of the Lilly board of directors; J. K. Lilly, president from 1948 to 1953, is board vice-chairman. Since 1953 Eugene N. Beesley has been president of the company, the first nonmember of the Lilly family to hold the office.

In the 82 years since Colonel Eli Lilly founded the firm bearing his name, it has grown from a company of four employees to one employing 9,000, from a small laboratory operated largely with hand labor for a local market to a business covering several city blocks and global in its reputation and distribution.

Why is the Ophthalmologist Sued?

The ophthalmologist, like any other physician, is legally negligent only when he fails in a duty to a patient and that failure results in damage. Most common malpractice charges: failure to remove foreign objects from injured eye, administration of improper and harmful medicine, negligent erroneous diagnosis.

George A. Friedman, M.D., LL.M.

It is fundamental that the state can regulate the practice of medicine under its police power for the public health and welfare.

But are optometrists brought within the statutes regulating the practice of medicine? Can the acts of a licensed ophthalmologist who practices only optometry be controlled by these statutes?

Questions such as these arise because the work done by the eye specialist physician and that done by the optometrist overlap to a certain limited extent.

Ophthalmology is the science which treats of the physiology, anatomy and diseases of the eye. It relates to the practice of medicine and surgery in the treatment of diseases of the eye.

"An ophthalmologist is a duly licensed physician who specializes in the care of the eyes. An optometrist examines eyes for refractive error, recognizes (but does not treat) diseases of the eye, and fills prescriptions for eyeglasses. The optician is an artisan qualified to grind lenses, fill prescriptions and fit frames."[1]

In *State v. Yegge*,[2] defendant was convicted of practicing medicine without a license. He al-

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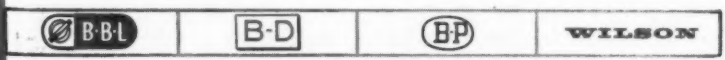

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leged that all he did was fit glasses to the eye. But he held himself out as an ophthalmologist and claimed to cure headaches, nervous troubles and female disorders. Conviction was upheld on appeal.

The mere examination of the eyes and the fitting of glasses to correct the defects discovered does not constitute the practice of medicine and surgery. The acts and conduct of the practitioner determine for the most part whether or not he is engaged in the practice of medicine.

In a 1938 Massachusetts case,[3] a registered physician diagnosed optical defects, deficiencies or deformities and prescribed lenses or prisms for their correction or relief. He used no drugs and performed no surgical operations. The designation "M.D." was on his door and his registration was prominently displayed.

He and his associate, a lay optician, obtained business through advertising. The Board of Registration in Medicine attempted to cancel his registration. The court held that although petitioner was a licensed physician, he was not engaged in the practice of medicine, and his registration accordingly could not be cancelled.

Power

The state has the power to prohibit even opticians from advertising or soliciting the sale of glasses, frames or other optical equipment by the public.

In 1955 the United States Supreme Court held constitutional an Oklahoma statute which prohibited such advertising; which also prohibited an optician from fitting or duplicating lenses without a prescription from an ophthalmologist or optometrist, and which barred operators of retail stores from furnishing space therein to any person purporting to do eye examination or visual care. The court said:

"It [the statute] is an attempt

to free the profession, to as great an extent as possible, from all taints of commercialism. . . . It may be deemed important to effective regulation that the eye doctor be restricted to geographical locations that reduce the temptations of commercialism . . . in a legislative program which aims to raise the treatment of the human eye to a strictly professional level."

So while the optometrist and optician are not usually regulated under the "practice of medicine" statutes, states continue to regulate them in similar ways because of their close relationship to the field of medicine.

Care necessary

The degree of care required of an ophthalmologist, as of any specialist, was set fourth by a California court as follows:

"One who holds himself out as a specialist in the treatment of a certain organ, injury or disease, is bound to bring to the aid of one so employing him, that degree of skill and knowledge which is ordinarily possessed by those who devote special study and attention to that particular organ, injury, or disease, its diagnosis and its treatment, in the same general locality, having regard to the state of scientific knowledge at the time."

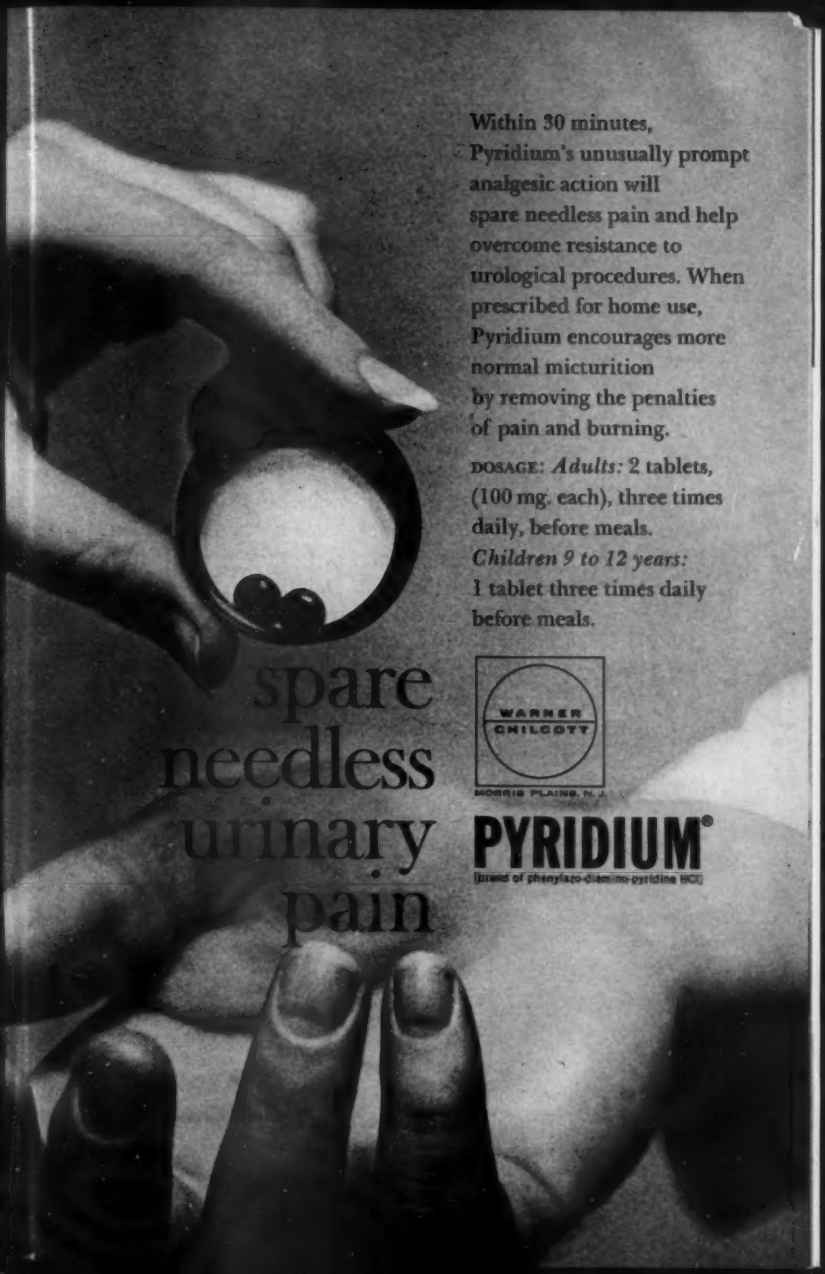
If a physician possesses and exercises the required degree of skill or care he is not liable for injurious consequences to his patient. He is not liable as negligent therefore because of the mere fact of want of success or poor result from his treatment—unless it is shown to be due to want of due skill or care or both on his part.

In *Adams v. Boyce, et al.*,[4] defendant physicians failed to remove a foreign object from plaintiff's right eye by use of a magnet. Further surgery was considered inadvisable.

Plaintiff lost the sight of his right eye. The physicians properly examined and x-rayed the eye, located the foreign body and were unable to remove it. It was held that due care was used in all their actions. Plaintiff was denied any recovery.

Proximate cause

"Eye injuries present . . . [a] field of malpractice where the cases reveal difficulty in distinguishing between the results of the alleged malpractice and ordinary and unavoidable results of the treatment or the original injuries, especially since, due to the delicacy of the eye structure, even a slight injury may produce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Within 30 minutes, Pyridium's unusually prompt analgesic action will spare needless pain and help overcome resistance to urological procedures. When prescribed for home use, Pyridium encourages more normal micturition by removing the penalties of pain and burning.
DOSAGE: *Adults:* 2 tablets, (100 mg. each), three times daily, before meals. *Children 9 to 12 years:* 1 tablet three times daily before meals.
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very serious results and surgery is seldom undertaken except in cases where the loss of vision is threatened as an effect of the diseased condition."[5]

In these cases, as in every case of negligence, plaintiffs must prove not only that physician failed in a duty to patient but that this failure resulted in injury. It is this proximate cause which is so difficult to establish in cases of eye injuries since defective vision, loss of eye or other resulting damages may easily have developed from the original injury to the eye rather than from subsequent treatment.

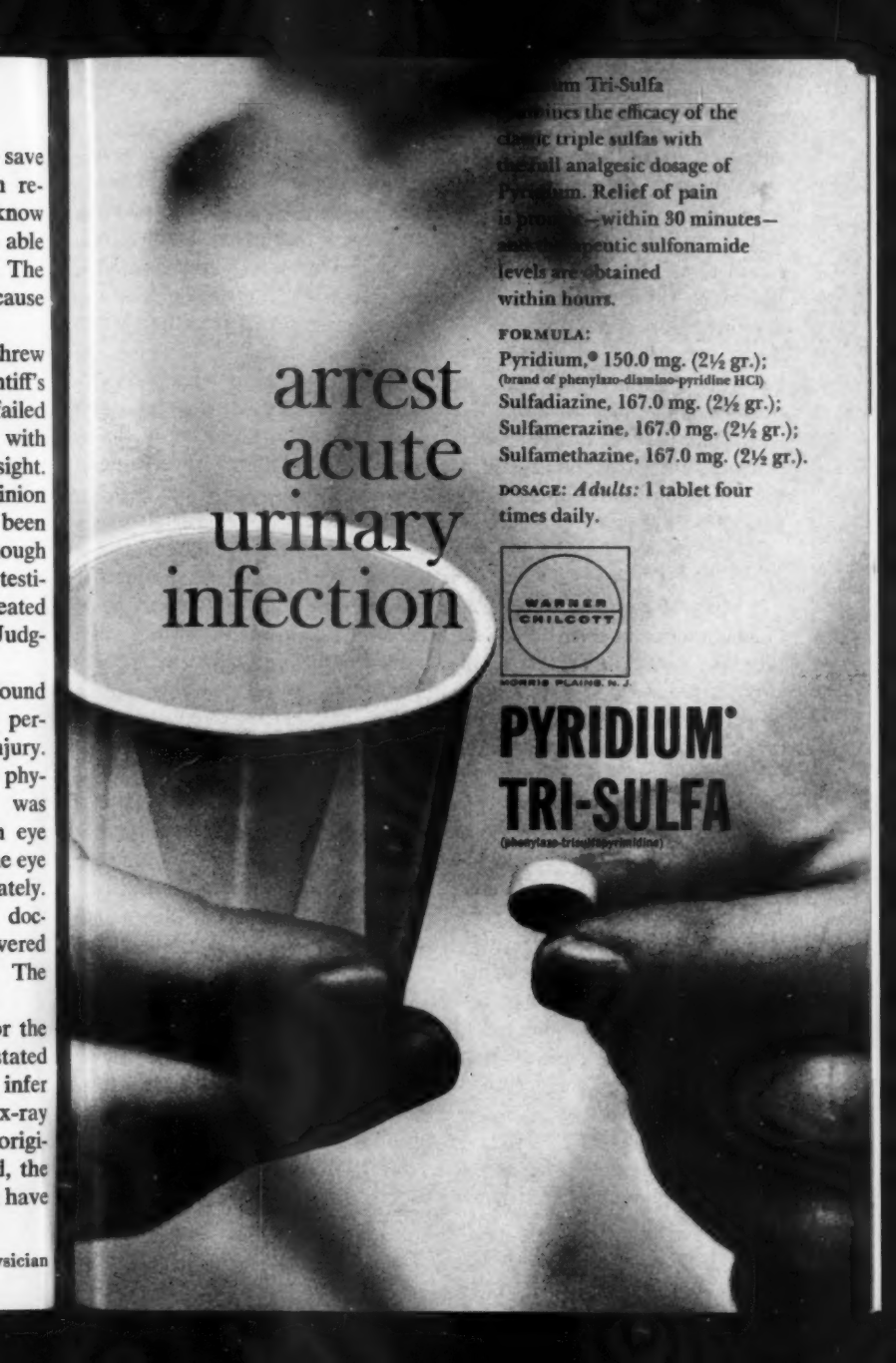
In *Jensen v. Findley,*[6] the court said that even if it were assumed that good practice required the defendant to cap plaintiff's right eye in the course of treating the other eye for gonorrheal ophthalmia, the failure to do so furnished no ground for action since the eye which was not capped did not become infected and was not injured in any way. The injuries complained of were in no way related to this failure to cap the eye.

In an Illinois case, defendant physician failed to send plaintiff to hospital at once for treatment. The physician who finally treated the eye for gonorrheal ophthalmia stated that while there *would* have been a better chance to save the eye had treatment been received earlier, he did not know whether he would have been able to save the eye in any event. The court held that proximate cause was not established.[7]

A refrigerator explosion threw sulphur dioxide gas into plaintiff's eyes. Defendant physician failed to promptly wash them with water. Plaintiff lost eyesight. The consensus of expert opinion was that nothing could have been done to help plaintiff, although some of the medical experts testified they would have treated plaintiff's eyes with water. Judgment was for defendant.[8]

In other cases, the court found that defendant's failure to perform a duty did result in injury. In *Madis v. Stellwagen,*[9] the physician discovered a needle was missing after performing an eye operation upon plaintiff. The eye was not x-rayed immediately. Eleven days later, the same doctor did x-ray the eye, discovered and removed the needle. The eye lost its vision.

In upholding judgment for the plaintiff, the appellate court stated that the jury had a right to infer from the evidence that if x-ray had been utilized before the original operation was concluded, the presence of the needle would have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been discovered, it would have been removed, and the eye *might have been* saved.

In a 1944 case,[10] defendant failed to sterilize his instruments and wash his hands before performing an operation on plaintiff's eye. This was undisputed negligence. Plaintiff's eye became infected and lost its vision. The court held that the failure to sterilize was the proximate cause of the infection and upheld damages of $5000.

Common types

The most common allegations of malpractice in cases of eye injury are negligent erroneous diagnosis, failure to remove foreign objects, administration of improper and harmful medicine, and other instances of negligent treatment as, for example, failure to advise hospital care or failure to warn of seriousness of disease or initial injury so as to put plaintiff on his guard.

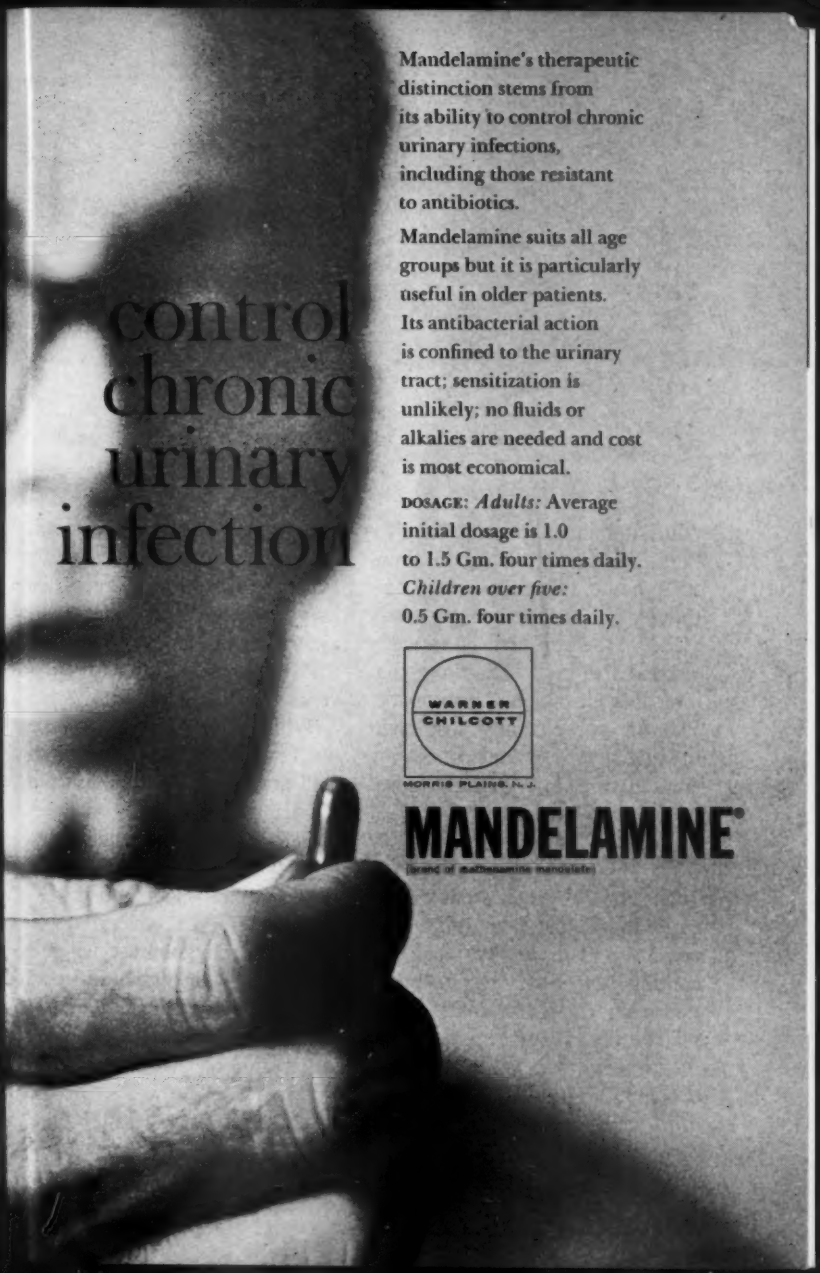
A large proportion of eye injuries arise from the accidental introduction into the eye of foreign objects, and a number of malpractice cases have been based on the doctor's alleged negligent failure to discover and remove such objects.

These cases have frequently turned upon the question whether prompt removal would have been helpful in any event, since, if not, the negligent failure to remove the object creates no liability. In most of these cases involving eye injuries from foreign objects, it has been held that causation was not proved.

Thus, in *Kosak v. Boyce*,[11] while the physician defendant was admittedly negligent in failing to x-ray plaintiff's eye to determine whether there was a foreign object in it, defendant was not liable for his negligence since the damage to the eye occurred at the time the steel object entered it and even its instant removal could not have saved the eye.

On the other hand, courts usually permit an inference of casual connection where harmful medicine in the form of eyedrops is administered, even in the absence of expert testimony. In one such case, a physician successfully removed a cataract from plaintiff's eye. Four days later, plaintiff returned for inspection of the eye. At that time, he was feeling fine and had moderately good vision which kept improving.

Physician inserted a caustic solution in the eye (its composition was not brought out in court); the plaintiff experienced a burning sensation and much



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pain later in the day. That evening, the doctor rushed to plaintiff's home, 40 miles away, although he had never previously visited there, and frantically washed the eye, exclaiming that a terrible mistake had been made. Plaintiff subsequently lost sight in that eye. Damages in the amount of $8500 were sustained by an appellate court.[12]

Diagnosis

In a 1940 Virginia case,[13] the court found that plaintiff's blindness was caused by negligent continuation of tryparsamide treatment after plaintiff complained his eyes were affected by it. In this case, expert testimony brought out that syphilis was a possible cause of the blindness. The appellate court held it was equally probable that the medical treatment caused blindness. Special care should have been taken in giving this drug since it was known to the medical profession that it was apt to have an adverse effect on the eyes.

While it is true that "where due care, diligence, judgment and skill are exercised, a mere failure to diagnose correctly does not render a physician liable,"[14] a physician must answer for a negligent erroneous diagnosis.

An $18,000 recovery was had in a 1942 Oregon case when defendant's negligent failure to discover glaucoma resulted in loss of vision in one eye and partial destruction of vision in the other. Defendant made no test for glaucoma either in the initial examination or during visits for further

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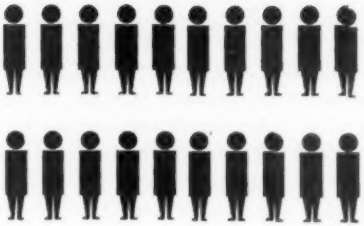

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1. Brit. M. J. 1:407, 1952. 2. Bull. Margaret Hague Mat. Hosp. 1:68, 1948. 3. Am. J. Obst. & Gyn. 57:541, 1949. 4. Connecticut M.J. 14:930, 1950. 5. J.-Lancet 66:218, 1946. 6. Am. J. Obst. & Gyn. 62:947, 1951. 7. Am. J. Med. Sc. 212:76, 1946. 8. Obst. & Gynec. 5:201, 1955. 9. J. Ped. 41:170, 1952. 10. Ann. Int. Med. 42:458, 1955.

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treatments although plaintiff's eyesight gradually deteriorated.[15]

A second physician whom plaintiff consulted immediately discovered the glaucoma and took steps to arrest its development. That physician testified that glaucoma was one of the first things a doctor should have looked for on the facts of the particular case.

Statute of limitations

As a general rule in most jurisdictions, the statute of limitations begins to run from the date of the wrongful act or omission (except in the case of fraudulent concealment), and not from the date of the damage caused or from the time the plaintiff discovered the damage.

Pennsylvania has a two year statute of limitations for malpractice actions. Defendant ophthalmologist in that state represented to plaintiff that a certain operation was not serious, that "there is nothing to it;" that the operation would correct her vision and enable her to dispense with glasses.

Plaintiff sued not on any theory of negligent treatment, but on the alleged "fraudulent" representation that the operation was not serious. The first operation made necessary a second and then a third operation. The court held that the injury was done at the time of the first operation and the statute of limitations began running at that time even though plaintiff was then unaware that there was any injury.[16] The alleged "fraudulent" representation could easily have been discovered within the two year limitation period by consulting with other eye specialists. It was not dependent upon the conclusion of all the operations. Since more than two years elapsed after the first operation, plaintiff was barred from bringing suit.

Not suspended

The running of the statute of limitations is not suspended by the mere fact that treatment continues after the original act. But where the injurious consequences arise from a course of treatment, the statute does not commence to run until the course of treatment is terminated. The malpractice is regarded as a continuing wrong and the fact that a substantial portion of the injury resulted before completion of the treatment is immaterial.

In *Shives v. Chamberlain*,[17] which occurred in another jurisdiction with a two year limitation statute, plaintiff sued for loss of vision of right eye and impair-

ment of vision of left eye as a result of negligent failure to diagnose the condition of glaucoma in either or both eyes. The loss of vision in the right eye occurred more than two years before institution of legal action, but treatment to the other eye continued within the two year limit.

The court held that plaintiff could recover for loss of vision of the right eye as well as impairment of vision of the left. The psysician's continued treatment constituted a continuing wrong causing the statute of limitations to start running only when the treatment ceased. Treatment of one eye could not be separated from treatment of the other in this case.

The testimony of an ophthalmologist was significant in a New York case in workmen's compensation. Accident caused loss of sight in plaintiff's left eye. Plaintiff refused permission for removal of the sightless eye. His right eye subsequently lost its vision due to sympathetic ophthalmia. He sued for loss of vision in *both* eyes.

The issue before the court was whether it was unreasonable for plaintiff to refuse to permit removal of his sightless left eye. The court held his refusal was justifiable inasmuch as the operating ophthalmologist had testified that, in his opinion, sympathetic ophthalmia would not occur.[18]

Compensation

Accidental firing of a gun caused glass and other bits of debris to enter defendant's eyes. He was rushed to a nearby charity hospital and operated upon by plaintiff physician, who admittedly saved his sight. Defendant, who was not a charity patient, was then moved to a noncharity hospital.

Plaintiff inquired after patient while he was in the second hospital but made no further examination. Patient made one or two office visits to plaintiff after his discharge from the hospital until his eyes were healed. The doctor then billed defendant for $250.

The court held that although the physician performed valuable services for the defendant, most of his work was performed while defendant was a patient at the charity hospital, for which plaintiff admittedly could not be reimbursed. An allowance of $100 was made for the doctor's other services to defendant.[19]

Damages

The amount of damages for eye injury varies in each case.

There is no established amount for loss of sight in one or both eyes, or damaged vision. The type of negligence in each case, in addition to the kind and degree of injury and damage, probably has much to do with awards made by a jury.

In a California case some years ago, a $15,000 judgment was awarded plaintiff for loss of the right eye after a nasal operation for asthma.

In another case a student was awarded $5000 damages when physician mistook him for another patient and applied certain drops to his eyes which caused pain, headache and discomfort to the student for several months, but no permanent damage.

In *Dean v. Dyer*,[20] $8500 was awarded when physician erroneously and negligently inserted a caustic solution in plaintiff's eye, causing loss of sight in that eye, despite the fact that vision in the eye would have been imperfect in any event.

A sum of $18,000 was awarded to plaintiff for loss of sight in one eye and damage of vision in the other caused by negligent, erroneous diagnosis of glaucoma in *Shives v. Chamberlain* (previously mentioned). When defendant attempted to limit damages to deterioration of vision in one eye, claiming that damages for the loss of vision of the other eye was barred by the statute of limitations, the court stated that it could not proportion damages in such a case and hold a certain amount represented damages for injury to one eye and another amount damages for the other. Both eyes figured here as a unit, not separate objects.

This type of reasoning could be significant in holding a defendant liable for injury to both eyes where he has injured one eye and resulting sympathetic ophthalmia impairs vision in the other eye.

A verdict of $5000 was upheld in an Arkansas case in the 1940's when physician's failure to sterilize his instruments and wash his hands caused loss of vision in the eye upon which defendant operated.

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U.S. 694, 85 L. Ed. 449.

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11. 201 N.W. 757, 185 Wis. 513 (1924).

12. Dean v. Dyer, 149 P. 2d 288, 64 Cal. App. 2d 646, (1944).

13. Reed v. Church, 8 S.E. 2d 285, 175 Va. 284 (1940).

14. Adams v. Boyce, et al., supra, note 4, at p. 1049.

15. Shives v. Chamberlain, 126 P. 2d 28, 168 Or. 676 (1942).

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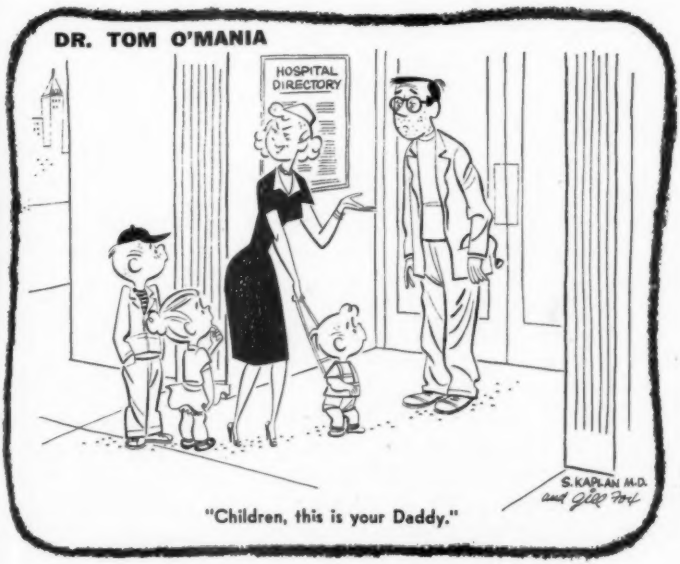
17. Supra, note 15.

18. Franeschetti v. Solway Process Co. et al., 254 A.D. 717, 4 N.Y. S. 2d 123 (1938).

19. Haik, v. Birou, 15 So. 2nd 388 (La. Court of Appeals, 1943).

20. Supra, note 12.



Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association.*

Answers will be found on page 197

1. In an outbreak of infectious hepatitis mainly among children attending two elementary schools the most appropriate measure would be to:

(A) Immunize all other pupils with gamma globulin.

(B) Make a door-to-door survey of the section to search for hidden cases and a common source of infection.

(C) Publicize the facts and advise general measures of personal and home hygiene and sanitation in the area.

(D) Close the schools.

(E) Isolate the cases and immunize the known contacts with gamma globulin.

2. If blood from a person with the "sickle cell trait" is transfused into another person, the type of individual in whom the cells would show an abnormally short survival rate is:

(A) Any one who has Banti's syndrome.

(B) Any one with an acquired hemolytic anemia and positive Coombs' test.

(C) Any one who has congenital hemolytic jaundice.

(D) Any normal person.

(E) Any one who has sickle cell anemia.

3. Hutchinsonian teeth as seen in congenital syphilis are:

(A) Upper central incisors with oval shape and notched biting edges due to development hypoplasia.

(B) Small teeth stained yellow from effects of syphilis during the months of infancy.

(C) Impacted third molars caused by hypoplasia of both alveolar ridges.

(D) Widely spaced teeth in the upper jaw due to hyperactivity of the maxillary alveolar periosteum.

(E) Soft teeth due to lack of calcium deposition.

4. A complication which may occur as a result of the use of ion exchange resins in the management of heart failure is:

(A) Direct toxic effect on the liver.

(B) Acidosis.

(C) Alkalosis.

(D) Digitalis intoxication.

(E) Direct toxic effect on the kidney.

5. The initial site of renal tuberculosis as seen by pyelography is usually in the:

(A) Infundibula.

(B) Tip of the pyramids.

(C) Ureter.

(D) Pelvis.

(E) Glomerulus.

6. When x-ray and fluoroscopy reveal a metastatic pulsating lesion in bone, the chances are great that it arises from the:

(A) Breast.

(B) Lung.

(C) Pancreas.

(D) Liver.

(E) Thyroid.

7. The usual leukocyte picture in luetic paroxysmal nocturnal hemoglobinuria is a:

(A) Leukopenia with an absolute lymphopenia.

(B) Leukopenia with relative lymphocytosis.

(C) Normal white cell count and differential.

(D) Leukocytosis with absolute neutrophilia.

(E) Normal total white cell count with lymphocytosis.

8. Constipation, extreme pain on defecation, blood after stool, followed by sphincter spasm, usually characterizes:

(A) Carcinoma of the rectum.

(B) Anal fissure.

(C) Anal fistula.

(D) Ulcerative colitis.

(E) Hemorrhoids.

9. In order of frequency as a cause of stricture of the common and hepatic bile ducts, operative injury ranks:

(A) First.

(B) Second.

(C) Third.

(D) Fourth.

(E) Last.

10. Meralgia paraesthetica is caused by lesions of the:

(A) Ilio-inguinal nerve of the thigh.

(B) Femoral nerve.
(C) Iliohypogastric nerve.
(D) Genitofemoral nerve.
(E) Lateral femoral cutaneous nerve of the thigh.

11. Attempts at flexing the distal phalanx of the index finger test the function of the:
(A) Median nerve.
(B) Flexor carpi radialis.
(C) Extensor carpi radialis.
(D) Radial nerve.
(E) Ulnar nerve.

12. If a patient who has a macrocytic anemia is found to have a low plasma iron level, the most likely diagnosis among the following would be:
(A) Anemia due to phenylhydrazine poisoning.
(B) Sprue.
(C) Macrocytic anemia of sickle cell disease.
(D) Uncomplicated pernicious anemia.
(E) Aplastic anemia.

NOTE: If you are interested in preparing questions for *"Mediquiz"* or the Professional Examination Service, write for information to the Professional Examination Service, 1790 Broadway, New York 19, New York.

What's the Doctor's Name?

by Victor R. Jablokow

He was born near Tehran, Persia, in the 9th century, in the town of Ray, from which his name is taken.

In his early life, he was a musician, physicist and alchemist. He began the study of medicine in his 40th year and became a major figure in Arabic medicine.

He was head of the hospital at Ray and then of one at Baghdad. It is said that he chose the site for the latter by hanging pieces of meat in various locations and choosing that place in which the meat showed least putrefaction.

He wrote about 237 works, one-half of them medical. Other subjects were theology, philosophy, mathematics, astronomy, grammar, music, chess, matter,

space, time, motion, nutrition, growth, putrefaction, meteorology, optics and alchemy. His greatest work, "Al Hawi" (the Compendium or Liber Continens, in the Latin translation), is an encyclopedia of medicine and surgery in 25 books.

His work best known to modern medicine is "Treatise on Small Pox and Measles," the first known monograph on the subject.

He used animal gut in sutures and introduced mercurial ointment, described spina ventosa and showed the swelling caused by guinea worm to be due to a parasite. He described the recurrent laryngeal nerve.

For his failure to convert base metal into gold, a local ruler ordered that he be beaten on the head with his own book until one was broken. As a result, he was blind in the last two years of his life. He refused operation, one story has it, because he discovered that the surgeon knew nothing about the anatomy of the eye. Another version is that "he had already seen too much of the world."

He died in poverty in 925 or 926, having given away in his lifetime a vast fortune to the poor.

Can you name this doctor?

Answer on page 197.

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